State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 7, 2007 **Physician** Feimer 8:00am E. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Crofton Anne Arundel Household of Angels 8. Date of Birth (Month, Day, Year) Nov. 02, 1912 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗑 F 95 Yrs. 212-20-0176 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Pasadena Maryland Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 249 Seneca Terrace 21122 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 ☐ Widowed 4 🔀 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) the University Bookeeper 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Ρ. Ρ. Margaret George Luckhardt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and artitle and the street of Health and the street of the st Maryland 21122 Department of Health Important: If item 27 any Injury or other tronce. 249 Seneca Terrace, Pasadena, Julia A. Morgan (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Buriai 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Brooklyn Park, Maryland 11-10-07 4 Donation 5 Other (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service License 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) neum on1 1 week **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an cate has certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3□ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1011 Berez MD 2225 E Defense Hwy, Croft on, MD 21114 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Funeral

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State of Maryland / Department of Health and Mental Hygiene 007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Lillian Falk 7:04 A M November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Battimore Baltinore Cita N/A 8. Date of Birth (Month, Bax, Year) Jan. 26, 1939 Pennsylvania If Under 1 Year | If Under 24 Hrs 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 M 2 K 193-30-3443 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Belfast Road 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Publid Elementary/Secondary (0-12) College (1-4or 5+) 5+ School System Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Wolonouski Simonitis 2 Marv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Falk/Husband 114 Belfast Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 11/9/07 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, maryland 21204 plications that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Acute myo cardial how disease or condition resulting in death) Due to (or as a contribution of): Sepsis 2 months Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner 2 months Intra-abdominal abscess Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation (Month, Day Year) 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBBS Res 000 November 7 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bautimore HOSpital of MBBS Remilekun Dosumu Sinai 31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 0 9

Registrar DHMH 17 Rev 1/2001

State

			For State	ate of Marylan	•				ental Hyg	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Deam		2. Date of Dea	th 2	107	3.3 in 5.0 a. 3
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	/Medic		4a. Facility Name (If not institution, give stree		J	4b. City, Town, o	or Location		110 V CITIOC	4c. Count		111.15 K
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ì	Director		216-24-6146 X N Usual Residence of Decedent						Aug 1,	1929	Mal	yland
	laryland show ed at		10a. State 10b. County		, Town or Loc				-		1	0d. Inside City Limits
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1 0	Pages 1 nent of He int: if iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Remo	val from State	emetery, cren	sition (Name of natory or other pla			ate	20c. Location	•	
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ם מ	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Consequence Martin D. Lawson		M1 65	Name and Addr TCHELL—V 00 York	VIEDER Road	ELD Bal	FUNERAL timore,	HOME, Maryla	INC. and 2	1212
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spiosa	s bee	olete							24a. Was		. Were auto	opsy findings available
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5	tai or s afte ai Dir ed n	Cert	4 Homicide	building, etc. (Specif	r) 				City of Tov	vri, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying Physicia (Check only one) 1 Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the t vestigation, in my	time, date a opinion, de	and place, eath occurr	and due to the red at the time,	cause(s) and n date and place	nanner as s e, and due f	stated. to the cause(s)
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	Sta	te.	Francis X. Carmody, 31. Date filed (Month, Day, Year)	M.D. 7505 32. negistrar's Signa	Osler ture	Drive,	Towso	n, Ma	ryland	21204		
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07-08496 Harold E. Galentine

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arold E. Galentir		State of Maryland / Department of Health and Mental H For State Certificate of Death		eg. No.	2007 3600
Physiciar		egistrar . Decedent's Name (First, Middle,Last)	2. Date of Dea	ith	3. Time of Death
ledical Examin	er	Harold Edward Galentine	Month Novembe		11201115
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Raltimore Washington Medical Center Glen Burnie	h	4c. Count	y of Death Arundel
<u>'</u>	-	Baltimore Washington Medical Center Glen Burnie Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr.	s. 8. Date of Bi	rth(MM/DD/YY	(Y) 9. Birthplace (State or
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	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
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re, F. I. and Thealt Titem		20a. Method of Disposition Entombment 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		on - City or Town, State
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Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma migury or other traumatic er	ſ	21. Signature of Funeral Service Ideansee 22. Name and Address of Facility G 169 Riviera Dr			
Physician *	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory a	rrest, shock, or	heart Approximate Interval
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	ed at the time, d	ate and place,	and due to the cause(s)
To with	Me	29b. Signature and title of certifier 29c. License number			signed (Month, Day, Year)
		Pameter Southou, MD		Novem	ber 2, 2007
5 1		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itstate operary it ans 8873 epatring in the alth and Mental Hygiene AMEND #4b, perPHYSert 6877 11 By AT, WS 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:15 P **GROSS** PETER RODNEY OCTOBER 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S MITCHEVILLE Bowie VILLA ROSA NURSING HOME If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F 031-28-3565 70 Director 09/25/1937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Counts 1 ☐ Yes 2X No PRINCE GEORGE'S **AOUASCO** Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20608 Funeral 16601 ST. MARYS CHURCH ROAD 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be COHEN GROSS ANNA MARTIN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16601 ST. MARY'S CHURCH ROAD - AQUASCO, MD 20608 JULIET MAYES GROSS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)
PRIDE OF JACOB Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State BOSTON. MD 11/04/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final **Physician** n + eles disease or condition resulting in death) /Medical (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2NH ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check or Medic one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature title of certifi 2261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carle us 2070x 9500 MM anna 31. Date filed (Month, Day, Year) 3 Registrar's Signature State

Registrar

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edical Exami	ner		RULFF			lb. City, Town, or L	acetion of F		er 6, 2007	ounty of Deat			\dashv
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Director	-	5 Social Security Number 212- 217-76-3028	1 M 2 X F	48	Yrs	Months Days	Hours	Apr.	22, 1	959 0	ountry) N	Marylar	nd
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36 in 72 han "	mpleted	Elementary/Secondary (0-12 12	College	(1-4 or 5+)	Rural	Mail Car	rier		U.S	. Post	al Se	ervice	
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Ball permit Depart Impor		21. Signature of neral Service	e Licensee		Mo	Name and Address COMAS Fu	neral	Home, P.	.A.	Mara	Dae Iv	21009	
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To the Hospital within 24 hours To the Funcral completely fille		29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the taxaminer:On the bas	pest of my knowled is of examination	edge, death oco n and/or investig	curred at the time, on the same of the sam	ate and pla in, death oc	curred at the time,	date and pla	ce, and due t	to the caus	e(s)	
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	2	255. Organization and the Coeff	1 1	1		0.0	.M.E.		Nov	ember 7,	2007		
		30. Name and address of pers	on who completed o	ause of death (Ite	em 23a)								
8			eputy Chief Me			enn Street, Ba	Itimore, I	MD 21201					
	 State	31. Date filed (Month, Day, Ye	/	egistrar's Signa	ature	arte .							
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ince Richard He	1.	State of Maryland / Department of Health and Mental Fryg - For State Certificate of Death legistrar		ı. No. 2 1	07 3600
Physiciar	/ 1	1. Decedent's Name (First, Middle,Last)	Date of Death Month November		3. Time of Death
ledical Examin		Lance Richard Healy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	vovember	4c. County of Deat	
	•	7206 Centerville Hall	ark	Prince Georg	
Funeral Director	Ę	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8	B. Date of Birth	Co	rthplace (State or Foreign buntry) SSachusetts
	1	Usual Residence of Decedent			10d. Inside City Limits
nd show any		10a. State 10b. County 10c. City, Town or Location MA Middlesex Stow			1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	untry?
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215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f shr ent, the Medical Examiner must be notified at once	= 1	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Research of Company) 14. Was Decedent of Hispanic Origin? (Specify Research of Hispanic Origin? (Specify Researc	can, etc.)	White, etc.	noan malan, stasin,
ter de:		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Wh:	ite
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21; nould be to Men is mar	리	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus			te, Zip Code)
Baltimore, MD 21215-00 pernit. Pages I and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the M.	-	Richard M. Healy (Father) 146 Boxboro Rd., Stow, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	MA UI Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	8/07	Name	N.S.A.
Itim it. Pag rtment ortant:	+	4 Donative of Funeral Service Licensee 22. Name and Address of Facility	707	Newton,	MA
Ba perm Depa Impe injur	- 1	Acton Funeral Home 470 Massachusetts A	ve., A	cton, MA 0	1720
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SiOI Atten r death ector: by the	cati	2 Accident Nov 1, 2007 0340 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only)	due to the cau	ise(s) and manner as s	stated.
To the within To the comple	edic	and manner stated.	tile line, date	29d. Date signed (
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		November 1, 2	
		30. Name and address of person who completed cause of death (Item 23a)			
5		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
	ate	A A A A A A A A A A A A A A A A A A A			
Regist	trar	NOV 0 9 2007 Region to figure			

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			For State Of IVIA		tificate of	neaim and Mer Death	Reg. I		3 6 0 0 0
Ī	Physici	an j	1. Decedent's Name (First, Middle, Last) Mary Jane Hahn				Date of Death	ጀታ , 2007	3. Time of Death 2:25 P M
1	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
4		:76	Genesis Cromwell Center			rkville		Baltin	
	Funeral Director		4 1 4 2 1	73 Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yea rch 31,1	9. Birth Cou 934 Mary	nplace (State or Foreign intry) yland
	ryland how at		10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	he Ma 28a-f s otifled	ectol	MD Baltimore	Pai	rkville		1.0		1 □Yes 2X No
	3a or	al Dir	10e. Street and Number 9020 Perring Park Road		10f. Zip Code 212	234	10g.	Citizen of What Cou USA	*
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Exeminer must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes, 2 N If Yes, Give Year or Dates:	0	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2X No	lispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Ameri Black, White Specify:	
2-0	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occup	during most of working	16b.	. Kind of Business/li	ndustry
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ylar	should be f and Mental H s marked of umatic eve	To	Martin Langhirt			Mary Regina			
Maryland	nd 2 sh Ith and 27 is rr r traum		19a. Informant's Name/Relationship (Type. Print) John Hahn-spouse	I		and Number or Rural Ro Park Road—Pa			
Baltimore,	Pages 1 an nent of Hea ant; If Item: ary or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Moreland, N	sition (Name of	Date	20c.	Location - City or T	Town, State
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	EVA	Name and Addre	ss of Facility 88 CHAPPI IS SERVICES P	00 Harford arkville,N	d Road Yaryland 21	1234
	tificate be executed 'Medical Examiner as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Limit underlying	the death. Do not entered. Consequence of: consequence of: consequence of: consequence of:	413	ng, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death Off 5
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ō	Physi or this o	5	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatier 27. Manner of Death 28a. Date of Injur	y 28b. Time of		4 A Nursing Home	5 Residence		ify)
Division or	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury ry - At home, farm, stre		Yes 2 □ No		and Number or Rui	ral Route Number,
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	To t Withi To ti	Ž	29b. Signature and title of certifier		29c. Licens			Date signed (Month	
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	2		30. Name and address of person who completed cause of de Werd, Klosz Mo 6701	ain (item 23a) (Type, F	SL S	te 4202 70	win pe	ne 2/20	y
	Sta		31. Date filed (Month, Day, Year) 32. Registra	r's Signature	andi s	1295-			
	Registr	वा	NOV 0 9 2007	Sed Sir flight	FEBRUAR CONTRACTOR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Phillip M. Haymond November 2007 11:20 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sav 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Hours Days Country) Utah Springville, 1 X M 2 □ F 528-38-8836 10/11/1934 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1√∑Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3036 Abell Avenue 21218 America
14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Government Library Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul M. Haymond Faye Averett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 West greenway Blvd. Falls Church, Virginia 22046 Peter Haymond/ son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State 8, 4 ☐ Donation 5 ☐ Other (Specify) 2007 Forest Hill, Maryland Chapel Bel Air 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a homa Kars Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE:

Physician /Medical Examiner Examiner law requires that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notifled at

the Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any injury or other traumatic event

Director

Funeral

δ.

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

detached page 2 s 24 hours after deatl • Funeral Director: filled in by

within 2

Hospital or Attending

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknowr
		4a. Was an autopsy prior to completion of cause of performed? ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐
25. Was case referred to medical examiner?	26. Place of Death (Che	ock only one)
1 ☐ Yes 2 ☑ No		5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ■ Natural 5 ■ Pending 2 ■ Accident investiga	(Month, Day Year) Injury Work?	Describe how injury occurred
3 Suicide 6 Could no 4 Homicide determin	ad 28e. Place of injury - At home, farm, street, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, ity or Town, State)
29a. Certifier 1- Certifying (Check only one) 1- Certifying 2 Medical E	Physician: To the best of my knowledge, death occurred at the time, date and place, and duaminer: On the basis of examination and/or investigation, in my opinion, death occurred at tand manner stated.	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

N. Chales St Bolts my 21205

Registrar DHMH 17 Rev 1/2001 6701

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** LEVETTE MICHELLE HARRIS /Medical 2007 11:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Index 1 Year If Under 24 Hrs. 2409 ST. STEPHENS CT. APT 1C 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 20XF Director 220-84-8970 July 29 1968 NEW JERSEY Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in the feath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or? STEPHENS CT. 2409 ST. Funeral APT 1C 21216 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade DISABLED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELTON HARRIS 2 BARBARA ALLEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If item 27 is or other train 2409 St. Stephens Ct., Apt 1C, ce of Disposition (Name of Date 2 Barbara Allen/Mother , Balto., Maryland 2121 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important; If it any injury or o once. WBurial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 11-10-07 LANSDOWNE, MARYLAND Signature of Fun al Service Liven es 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Mu 1206 W NORTH AVENUE 23g Part1. Enter the disease, or co shock, or heart failure. List on polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carcinona of Breast with matastasis unkowa disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Immune deficierry 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an nas e 2 s certificate ha autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) | Hospice 1 ☐ Yes 2X No ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

the Hospital or Attending Physician: in 24 hours the Funeral Directory filled in by within 24

State

Registrar

31. Date filed (Month, Day, Year)

2007

NOV 0 9

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a Standiford 3 egistrar's Signature

Richey Hospice Joseph

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

14383

29d. Date signed (Month, Day, Year)

Baltimore MD

NOV 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death

Physicia /Medic Examin	al
Funeral	

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or iteme 23a or 28a-1 show eny injury or other treumatic event, the Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer 5+ 17. Father's Name (First, Middle, Last) Be Martha Wheeler George Washington Housley 19a. Informant's Name/Relationship (Type, Print) Edith J. Housley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov 9 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral S M00382 Should rohi -eur Immediate Cause (Final Due to (or as a consequence of): Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transit une the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use es the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy ļ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No datached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 9 24a. Was an autopsy cartificate director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ၉ 1 🗌 Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural Injury 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aftar To the Funarei Dire 1 Certifying Physician: To the built of my knowledge death occurred at the time, date and plane, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64100 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 1500 Formest Glen Dr. Silver Spring Md 20910 mithe ape 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7, 6:45 AM M November 2007 Donald George Housley, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O1/16/1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 KS 182 M 2 ☐ F 90 508-09-5347 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20904-11815 Gordon Rd. Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 25 Married 1 Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11815 Gordon Rd. Silver Spring, MD 20904-20c. Location - City or Town, State Beltsville, Maryland 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

NOV 0 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** NOVEMBER 03 2007 Nancy Jane Hershey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 😾 F 80 Aug 13, 1927 Pennsylvania **Director** 201-20-5087 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 USA 1608 Woodlands Run Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Mamed 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>medical technician</u> healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Arlie Culler Ethel Zoe McConnell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Hershey/spouse 1608 Woodlands Run Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4XDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimere, MD 21201 23a. rt1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final peritonitis Spantaneous Due (or as a consequence of): Backensl **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hougace Examiner The law requires that the death certificate be executed attending physician and for use as the burial-translt Septic Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 NO 3 Probably 4 Unknown isease certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 □ Lepatient 2 □ ER/Outpatient 3 □ DOA ပ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours at To the Funeral D

Director: / filled in by

> State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

29c. License number N62588

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

November 3rd, 2007

Haperstown, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUDITH MISAOUA, TUS. 251 E. Anhicham St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 36013 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician **ALVERA** HICKS 11 06 2007 10:12 aM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BELNORD AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 □ M 2 ₩ F Yrs 220-64-7970 52 08-22-1955 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County X Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 BELNORD AVENUE 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XNo Specify. Specify: BLACK ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT HICKS **DELORES JONES** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PANDORA HICKS/SISTER 1620 LATROBE ST., BALTO., MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WESTERN STAR 11/15/2007 BALTIMORE, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee anges q. 1701 LAURENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Menal Diceone End Stage () Due to (or as a consequence of): Stage Sequentially list conditions, Date to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Nonknown

Physician /Medical Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified at

filed within 72 hours after death with the Maryland Hygiene.

s 1 and 2 should be filed w f Health and Mental Hygier tem 27 is marked other th

permit. Pages 1 and Beath Department of Heath Important: If item 27 any injury or other tra

Baltimore, Maryland 21215-0036

and burial-trai physician the as Š ate has been signed page 2 should be det this

The law requires that the death certificate be executed death. p

Division or Vital Records, P.O. Box 68760,

or Attending Physician: within 24 hours after death To the Funeral Director: filled in completely

Certification: To

Medical

				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No					
25. Was case referred to me	dical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
Z Accident	estigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred					
	28e. Place of inju building, etc	y - At home, farm, street, fac (Specify)	ctory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)					
	ifying Physician: To the best of lica! Examiner: On the basis of and manner sta	examination and/or investiga								

29c. License number

D00 640 63

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1 - For State Registrar		faryland	d / Depa <i>Cer</i>	rtment of I	lealth a		Re	g. No.	07	36014	}
Physic	cian	Decedent's Name (First, Middle,						2	Date of Deatl	Day	Year	3. Time of Death 750 AM	
/Med	lical		COCK			4h City Town	and a setion of	4 Dooth	NOV	8 Z	107	130 11	_
Exam	iner	4a. Facility Name (If not institution,	HOS D	ital		4b. City, Town,	time	-		4c. County	or Death		
Funoro		21.1.1.	5. Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year			I. Date of Birth		9. Birthpla	ce (State or Foreign	,
Funera Directo		228-22-5947	1□M 2 X F	81	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, UGUST	7ear) 5.1926	Countr	y) VA	
-		Usual Residence of Decedent											
nylar how	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10	d. Inside City Limits	
Ba-f	Sc.	MD		BA	LTIMO	RE				-		1 X Yes 2 □ No	
UU35 hours after death with the Maryland tural', or fleme 23e or 28e-f ehow at Examinar must be notified at	Directo	10e. Street and Number				10f. Zip Code			10	0g. Cilizen of W	hal Countr	y?	
e 23e	Funerai	244 S. MONASTER				212				USA			_
ter de	in in	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceden	?	5. 13. y	Vas Decedent of I Yes, specify Cub	an, Mexican	gin / (Speci , Puerto Ri	can, etc.)		e - America k, While, et		
15-0036 72 hours at "natural", or ofical Exam	by	3 Widowed 4 Divorced	d 1 Tyes 2 T If Yes, Give Year or Dates	_	1	☐ Yes 2 X No	Specify:			Specify:	BLA	CA	
72 hours		15. Decedent's				ent's Usual Occu				16b. Kind of Bu			_
within 7	pie	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-4or	5+)	(Give life. L	kind of work done OO NOT use retire	during most d)	of working	7				
A Maria	Completed	7	00090 (1 10	.,	CLI	ERK				REST	AURAN	T	
and 2	Be (17. Father's Name (First, Middle, L.	ast)				18. Mothe	r's Name (i	First, Middle, N	Aaiden Sumam	e)		
325 2	2	LEE REDD						RA KI					
Mar d 2 sho th and th end treum		19a. Informant's Name/Relationshi	p (Type, Print)			g Address (Street							
C = 14 F		LEROY REDD/SON		20h BI	Annal and Advisory	WATERCRI sition (Name of	EST CI	RCLE	-	CEVILL			_
0 % = 5		20a. Method of Disposition 1 😾 Burial 2 🗆 Cremation		9 06	ametery, cren	natory or other pla	(ce)			20c. Location -			
E 533		4 Donation 5 Other (Sp.		UN		METERY	1		4-2007			.H., VA	_
Departition of the control of the co		21. \$ignature of Funeral Service L	2. What	in		701-31 1				IMORE,		F.H., INC 1217	•
Physician		23a. 11. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that cause nly one cause on each aa	ed the death line.	t her	er the mode of dyi	ng, such as	Plec	respiratory arre	ffusio		Approximate nterval Between On at and Death	
/Medica Examine			b. Me	ta St	atk	Ca	/				n	2011 the	
ed slt	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a cons	ence of):	Ca						,	
8 / 60, cate be executed obysicien end the burial-transit	xan	thal initiated events resulting in death) Last	c. Due to (or a	s a consequ	uence (f):	COL					- 6	pars	
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ecords, P.O. Box bit law requires that the death certific as been signed by the ettending p. 2 should be detached for use as!	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, oulcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify) _	у			23d. Date Mor	e of delivery	y Day Year	
that the ded by deta	A.	Part II. Other significant condition	s contributing to death	but not resu	ılting in the ur	derlying cause gr	ven in Part I.		23e. Did tob	acco use contr	ribute to the	cause of death?	
VICAL RECORDS, P.O. Iclen: The law requires that the de certificate has been signed by the rector, pege 2 should be detached	ed by	CHF, Dia	sheles, h	mos	tens	ion			1 □ Ye	s 2□No	3 Proba	bly 4 Unknown	1
Bawre lawre as bee	Set	(•	14					24a. Was an	n 24b. V	Vere autop:	sy findings available pletion of cause of	,
* o - g	Completed								autops perform	ned:/ d	leath?	pletion of cause of	
VITAL P IICION: Th Certificate rector, peg	0	25. Was case referred to medical					26. Place	of Death /	Check only on	-	163 2		-
- × × ×	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Vin pal	ient 2 🗆 l	ER/Outpatien	3□ DOA Ot	ner: 4 🗆 Nui	rsing Home	5 ☐ Reside	nce 6 Othe	er (Specify)		
		27. Manner of Seath 1 Natural 5 ☐ Pending	28a. Dale of In (Month, D	ury ay Year)	28b. Time of Injury	28c. Inju Wo	ry at	28	d. Describe ho	w injury occurre	ed		_
	catio	2 Accident investiga					Yes 2 1	No					
DIVISION If or Attending effer death. Director: Afte	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of It	njury - At ho elc. (Specify	me, farm, stre	eet, factory, office		28	f. Location (Str City or Town	reet and Number, State)	er or Rural	Route Number,	
To the Hospital or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the	edicai C	29a Cartifier 1 Cartifying (Check only one)	Physicians To the bas caminer: On the basis and manner s	of examinat	wledge death ion and/or inv	occurred at the ti estigation, in my	me, data and opinion, deat	d place, an th occurred	d due to the sa Lat the time, da	iuse(s) and ma ate and place, a	nner 1s sta and due to t	he cause(s)	
To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licen:	se number		29	9d. Date signed	(Month, D	ay, Year)	-
. /		1 Amus		M	iD.	IIM	PP	198	64	Nous	8 2	2007	
37		30. Name and ad less of person w	ho completed cause of	death (Item	23a) (Type,		^	. 1 .				7.00	
\sim		AMARINDER	SANDHU	90	O Cate	on Ano	130	altiv	nero	MO	217	229	
_	tate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signat	ure	20 MP 123						1	
Regis	trar	NUV 0 9	LUU/ LA	5 B	1204	a final and a second							

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36015

rcia R	. Hollow	1-	State of Wai yland / Department of Death Reg. No. Reg. No. State of Wai yland / Department of Death Reg. No. State of Wai yland / Department of Death Reg. No. State of Wai yland / Department of Death Reg. No. State of Wai yland / Department of Death
	hysicia	ın/	egistrar 1. Decedent's Name (First, Middle,Last) Marcia R. Holloway 2. Date of Death Month Day Year November 4, 2007 1047 hrs
edinal	Examir		4b. City. Town, or Location of Death 4c. County of Death
4			3404 Old York Road Baltimore
F	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) Months Days Hours Min. 7 and 1 1 0 0 0 Country) Country Manual and 1
D	irector		218-82-0189 1 M 2XXF 47 Yrs. April 1,1960 Same Maryland
	any		Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10 x Yes 2 No
7		١	Maryland N/A Baltimore City
-	28a-f	Director	10e. Street and Number United States
× :	2 should be filed within 72 hours after deam with the manyanu hand Memler Hygiene. At an analysis is marked other than "natural", or items 23a or 28a-f show mantic event, the Medical Examiner must be notified at once.		3406 Old York Road 21218 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc.) White, etc.
8860	items items ust be	Funeral	1 Never Married 2 X Married Armed Forces?
≃ ;	affer de	by Fu	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 A No specify: Specify: Specify: WITTEE
	natur Exami	l be	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
36	led within 72 ho Tygiene. other than "na the Medical Ex	Completed	10 Years Own Home
215-0036	ed wit tygien other he Mo	S	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname)
2121	d be fil lental I arked event,	Be	Roy E. Plumb Lois Eppard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 2	shoul and N 27 is m	ဥ	John W. Holloway (Husband) 3406 Old York Road Baltimore, Maryland 21218
e Jej	l and Health item		20a. Method of Disposition crematory or other place)
mor	Pages lent of nnt: If or othe		4 Donation 5 Other Specify: Hilltop Service Corp.
Baltimore,	pernit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other th injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Home of Dundalk, Inc. 7022 History Avec Dundalk Maryland 21222
	ysician		23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart. Between Onset and
ر ت	1edical		failure. List only one cause on each line. Immediate Cause (Final disease a. Cocaine and heroin intoxication
	aminer	1	or condition resulting in death) Due to (or as a consequence of):
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):
1	uted nd ransit		
	ate be executed oblysician and he burial - transit	dica	X UNPENDED AMENDED #23a, 27, 28a-f, perME, g873, 11/16/07 TT 23d. Date of delivery
760,	ficate t g physi s the bu) §	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 687	th certi	ician	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown
89	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and the funeral Director: After this certificate has been signed by the attending physician and the funeral Director.	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.0	s that the greed b	2 2	1 Yes 2 No 3 Probably 4 V Charlem
5	require been si	Completed	24a. Was an autopsy minings available autopsy performed?
000	he law	S 7 agi	1 ✓ Yes 2 No 1 ✓ Yes 2 No
<u> </u>	an: Tl ertifica	ט ומי	25. Was case referred to medical
Division of Vital Records. P.O.	hysici r this c	al direct	1 Ves 2 No inpatient 2 ENOutpatient 3 204 Describe how injury occurred
2	rding h. h.	e tuner	
	r Atter er deat rector	th by th	2 Accident Investigation Investigation 3 Suicide 6 X Could not be Investigation 3 Suicide 6 X Could not be Investigation 11/4/2007 FIRE 10:40 July 2007 Fire 11/4/2007 FIRE 10:40 July 2007 Fire 200
2	ours aft	illed ii	3 Suicide 6 X Could not be determined (Specify) found at home 3404 Old State (Specify) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif	letely 1	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To th within	completely filled in by the tune	one) 2 Medical Examiner: On the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation, which is a signed of the basis of examination and/of investigation and investigation
		'	November 5, 2007
			30. Name and address of person who completed cause of death (Item 23a)
ار	0		Donitia W. Vincenti, W.D. Vices 32 Printer's Signature
	Rec	Sta gistr	NOV. 0.0 2007 Pagest

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** James E. Hilderbrand, Jr. November 5, 2007 8:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14835 New Hampshire Avenue Silver Spring
If Under 1 Year | If Under 24 Hrs. | 8.
Months | Days | Hours | Min. Montgomery 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Director 61 220-42-3598 September 20,1946 Maryland | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 27 No Director Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14835 New Hampshire Avenue 20905 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Affiled Follows.
1 ∑Yes 2 No.
If Yes, Give Vietnam
Year or Dates: Era within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 Mechanical Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James E. Hilderbrand, Sr. Catherine Grant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) item 27 I 14835 New Hampshire Avenue, Silver Spring, Maryland ace of Disposition (Name of Date 20c. Location - City or Town, State 20905 <u>Sandra L. Hilderbrand/ Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State permit. Pages 1 Department of H Important: If Iter any Injury or oth November rgomery orium Inc. 10, 2007 Bethesda, Maryland ^{22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805} 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Amyotrophic Lateral Sclerosis 18 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s nas autopsy performed? Yes 2X No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 🛱 Residence 6 Nother (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred : After t 28c. Injury at Work? Certification: Hospital or Attending 1 🕅 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

15+1

State Registrar David Harding, M 31. Date filed (Month, Day, Year) NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18111 Prince Philip Drive, Olney, Maryland 20832

1. Registrar's Signature

D35965

November 6, 2007

Thelma Elisabeth Harmon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex # **Funeral** 1 □ M 2 🛚 F Months Davs Hours Yrs. 96 1911 Washington, D.C. Director 577-10-6114 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County Director Montgomery Bethesda Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e **23**a 9237 East Parkhill Drive must 20814 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 11. Marital Status "natural", or items edical Examiner m hours after 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 12 should be filed within hand Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) Secretary American Red Cross 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Maurice Joseph Harmon Myra Jane Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 6163 McLendon Court, Alexandria, Virginia 22310 Date | 20c. Location - City or Town, State Valerie McNamara/ Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State November of Heaven Cemetery 12, 2007 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 755/Wisconsin Avenue Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHOROSCLMOTIC CARDIDVACULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 15th pm Due to (or as a consequence of). the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performed? 1□ Yes 23 No **Division or Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28a. Date of Injury 28h Time of 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ∏Yes 2 ∏No M To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier

OLD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

November

Month

Day

Year

Montgomery

United States

Race - American In Black, White, etc.

Specify:

3:16PM

10d. Inside City Limits

1 ☐ Yes 2X No

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

Wilwow

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

Year

Month

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) CENCETOWN RD. **ORIGINAL**

State Registrar

10

29b. Signature and title of certifier

BELLOW

31. Date filed (Month, Day, Year) **NOV 0 9 2007**

MI

1 - State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 36018 Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 Nov. Philip Henry Hokemeyer 11:50 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Funeral Days Hours Min 1 M 2 □ F 714-18-1470 84 23, 1923 Maryland May Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State show ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Parkville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8820 Walther Blvd., Apt. 1213 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give Year or Dates: 1942-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No altimore, Maryland 21215-0036 Specify: White Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Division Administrator Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William G. Hokemeyer Alice Edelen ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife/ Hokemeyer 8820 Walther Blvd., Apt. 1213, Parkville, MD 21234 Margaret Regec Freeman Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Vale (Sardens 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-10-2007 Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lice 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Due to (or as a co sequence of): areurysm (abdominal **Physician** hrs disease or condition resulting in death) /Medical Examiner Sequentially list conditions. Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, $C_{\!\scriptscriptstyle C}$ Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 morths? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ, 1 Yes 2 No 3 Probably 4 donknown certificate has been si rector, page 2 should Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 2□ No Yes 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

14.0,

Hokemeyer

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

8800 Walther Boulevard, Parkville, MD 21234

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7, 2007 November **Physician** 1:55A MABEL ARNOLD HAWKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Baltimore Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours August 29,1923 Maryland 1 □ M XX F 217-17-8798 84 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2☐No Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 166 Brandon Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (A)No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married XXMarried 1 ☐ Yes aXXNo White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Bellman Andrew Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is many injury or other 166 Brandon Road Baltimore, Maryland A. Charles Hawkins Hus. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 □Cremation 3 Removal from State Dulaney Valley Mem Gardens 11/10/07 4. □ Donation 5 □ Other (Specify) Timonium, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral Se / ce/Licens 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, healing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ician and burial-trans Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 B No for Month Dav Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Vital 1☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို Division or 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury Jospital or 44 hours after dea.

-ral Director: A*

- in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

1,2009

OvernBer

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

MAHMOOD

32. Registrar's Signature

43721

2300 Dulaney Velley RD

Timonium

MP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O 7 0048 A M **Physician** 2007 Walter Stanley Isensee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Square

5. Social Security Number Kosedale enter If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 € M 2 🗆 F 87 219-18-8908 1-21-1920 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 1 ☐Yes 21 No Directo MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 21236 USA 7718 Bennerton Drive Baltimore, MD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Crown, Cork& Seal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Ellen Burch Harry Isensee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 Flintrock Drive Bel Air, MD 21015 Linda Kelly Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition V) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith 11-12-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Livensee Schimunek Funeral Homes, Inc. 9705 Belair Rd Nottingham, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ocardia /Medical Due to (of as a consequence of) Examiner neumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed iding physician and ise as the burial-transit trial Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atten I be detached for u 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No or Vital Records, P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requin within 24 hours after death.

To the Funeral Lirector, After this certificate has been si completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Micrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State

Registrar

one)

29b. Signature and title of certifier

30. Name and address of person

Ayoola

DHMH 17 Rev 1/2001

29c Lieense number

Maire

29d. Date signed (Month, Day, Year)

and manner stated.

Myodele

2007

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9000 Franklin

			1 - For State Registrar	State of Maryland		rtment of H tificate of L		ental Hygie	2001	36021
	Physic /Medi		Decedent's Name (First, Middle, Last) D & VS	Jack	STU			2. Date of Death	Day 16 Year	3. Time of Death 3. 58A M
	Exami		4a. Facility Name (If not institution, give str Good Samaritan		ter	4b. City, Town, or Baltin	Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 220-20-0802 Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 12	ar) Co	thplace (State or Foreign buntry) Maryland
	Maryland f ehow	lor	10a. State 10b. County Maryland N/A		Town or Local			· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits 1
	3a or 28a	i Director	10e. Street and Number 2413 Fleetwood A	Venue		10f. Zip Code 21214			Citizen of What Co	A
36	be filed within 72 hours after death with the Maryland tla Hygiene. Id other then "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 12 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	lf	/as Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto F	cify Yes or No-	14. Race - Ame Black, Whit	e, etc.
215-0036	in 72 hours "natural", leuical Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's Educal (Specify only highest grade of	Year or Dates:	16a, Decede	ent's Usual Occupa			Specify: B Kind of Business 1timore	/Industry
	e filed within all Hygiene. Other then "yent, the West	Be Comp	Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last)	Coilege (1-4or 5+)	Educ	ator		1	blic Sc	-
Maryland 21	2 should be and Mental is marked o	ToB	Andrew Young 19a. Informant's Name/Relationship (Type)	Print)	19b. Mailing		Sadie Jo		ty or Town, State, a	Zip Code) 21214
_	es 1 and of Health f Item 27 r other tr		Ursula Slade/ Da 20a. Method of Disposition 1 ♀Burial 2 □ Cremation 3 □ Rem	ughter 20b. Plac	2413	Fleetwo	ood Aver	ue Balt	imore,	Maryland
Baltimore,	permit. Pages Department of Important: If It eny injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Plea	asant	Rest C	emetery	То	wson, M rris Fu	aryland neral Home
	8 8 2 0 3		23a. Part I Enter the disease, or complical shock, or heart failure. List only one	ions that caused the death.	52	40 Reis	terstowr	Rd Bal	timore,	Md 21215 Approximate Interval Between
Ž	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequer	10CEL	rdial	Emofa	ichion		Onset and Death LOS Thou
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequent	nce of):	fel	1,000	22 0		
8/00,	ficate be executed physicien and is the burial-transit	icai Exar	that initiated events c	Due to (or as a consequen	nce of):	ner o	wen			
\sim	To the Hospitel or Attending Physician: The law requires that the death certifical within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	eath 3 E	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
cords, P.V	uires that th signed by Id be detact	þ	Part II. Other significant conditions contrib	outing to death but not resulting	ng in the unc	derlying cause giver	n in Part I.	23e. Did tobacc		the cause of death?
מפנס	The faw req te has beer age 2 shou	Completed						24a. Was an autopsy performed	24b. Were au prior to death?	topsy findings available completion of cause of
- <u>V</u> [a]	ysician: is certifice director, p	To Be C	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} 20 \text{No} \) Hosp	oital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient	3□ DOA Other	26. Place of Death	1 Yes 2 1 Yes (Check only one) e 5 Residence		
	tending Ph feath. tor: After th the funeral	Certification: 7	1/20 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28	Bb. Time of Injury	28c. Injury : Work? M 1 □ Ye	at 28	8d. Describe how in		ary)
2	pitel or Al		4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				3f. Location (Street City or Town, Sta	ate)	
	ithin 24 ho ithin 24 ho orpletely	Medical	one)	an: To the best of my knowle On the basis of examination and manner stated.	and/or inve	stigation, in my opi	nion, death occurred	at the time, date a	ind place, and due	to the cause(s)
			29b. Signature and title of centifier Cuestin Tuestin	plead cause of death (Item 63	Co (Tuno B)	D	30661	NO	revier -	9th 2007
	Stat	te		32 Aegistrar's Signature	A M	allim	ole. M	x - 21	234	
	Registra	ar	NOV 0 9 2007	32 Registrar's Signature	SOS	Alfa. I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death Day Month Physician ones 2007 Nov /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Extended Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours 223-18-7677 88 Director 3/25/1919 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f sh 1 ☑ Yes 2 ☐ No Directo N/A BALTIMORE CITY MD the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a o 3211 PIEDMONT AVENUE 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give US Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ARMY 1 ☐ Yes 2 No Specify: BLACK Completed by 3€ Widowed 4 Divorced Year or Dates 1 9 4 2 - 4 5 "natural" er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked or traumatic ev EDWARD JOHNSON FANNIE LEE LUSTER P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau RITA CARTER 2610 AMHERST RIDGE LOOP, COLONIAL HEIGHTS, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/12/07 LAWRENCEVILLE, JONES FAMILY CEM. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death dia Cause (Final **Physician** emen /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? 2 1 No 2 No or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation ours after death. neral Director; A filled in by the fu 1 ☐ Yes 2 🗌 No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Hospital (4 hours at within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

3900

LOCH

31. Date filed (Month, Day, Year)

TIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVEN

BLVD

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** carline November 700 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Balti More If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 241.36.3940 1 □ M 2 💢 F Months Hours NC Director 10/09 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore MD 1 XYes 2 No Director Earline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4013 West Forest Park Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 2 Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10th grade Kuowa 17. Father's Name (Pirst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Earl Johnson Lucille Conrad 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson/Daughter Sharon R. 4013 West Forest Park Avenue Balto. MD 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Windsor Mill, MD 11/10/07 22. Name and Address of Facility Vaudhn, C. Greene Funeral SWCS 8728 Liberty Road Rindallstown MD 21133 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiothrombotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical the asi IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 s autopsy performe certificate Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) MSKUMPANZEM.D 00057465 . 11/7/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Mainst-Suite Zoo, Reisterstown, MD S. RujapaksemD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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п	Physici		1. Decedent's Name (First, Middle, Last) Mathias Kruelle						1 -	Month Nov.		Year 7	3:45	A M
	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of [4c. County of			
7	LXaiiii	Augsburg Lutheran Home						rn			Balt	imore	2	
16.	Funeral		Social Security Number 6. Security Number		ge (In yrs. la		If Under 1 Year Months Days		Hrs. 8 Min.	Date of Birth	Year)	9. Birthpla	ace (State o	r Foreign
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	the /	Director	10e. Street and Number		1		10f. Zip Code			10	g. Citizen of W	hat Count	ry?	
	h with	a D	6811 Campfield Rd				21207			1	USA			
	within 72 hours after death with the Maryland ene. ttan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces		3. 13. V	Vas Decedent of H f Yes, specify Cub	ispanic Origin	n? (Specit	fy Yes or No-		- America		
98	or its		1 Never Married 2 Married	1 □XYes 2 □ If Yes, Give			☐Yes 21☑No	Specify:		Juli (100.)		Whit		
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Maryland 21215-0036	uld be Aenta rked ric ev	To B	Henry Kruelle					Chris	stina	a Humme	1			
lar)	2 sho and ! is ma auma		19a. Informant's Name/Relationship (Ty	· · · · · · · · · · · · · · · · · · ·			g Address (Street						Code)	
≥, ≤	and sealth m 27		Mina Reiter-Niece				Yvonne A			imore, I				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	emoval from State	20b. Pla	ace of Dispo: emetery, cren	sition (Name of natory or other plac		Dat		0c. Location - 0	City or Tov	vn, State	
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Bal	permi Depa Impo any ir		21. Signature of Funeral Service Licens	e			Name and Addre			ler-Dip Ltimore	-		Home,	Inc.
	_		23a Pal Ener the disease or compl	ications that cause	d the death							_	Approximat	e
	Dhusisian		shock, or heart failure. Est only or Immediate Cause (Final	as complications that caused the death. Do not enter the mode of dying, such as cardiac or responsitionly one cause on each line.									Approximate Interval Bet Onset and I	ween Death
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a.A.THERD SCLEPOTIC EREPSE VAKCULAR DISEASE Due to (or as a consequence of):												
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Box 6	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	e pf pregnar	псу					23d Date	of deliver	rv	
ă	death certifii e attending p cd for use as	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant			Ectopic pregnanc; Other <i>(sp</i> ec <i>ify)</i>	/			Mor		-	Year
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S, P	requires that the de een signed by the a nould be detached f	by P	Part II. Other significant conditions con	ntributing to death	but not resul	Iting in the ur	nderlying cause giv	en in Part I.		23e. Did toba	acco use contri	bute to the	e cause of d	eath?
ord	w require been signature should b	led l								1 ☐ Yes	s 2□No	3 Proba	ably 4 Dk	Inknown
ec	law as b 2 si	Completed							_	24a. Was an autopsy	24b. V	Vere autop	sy findings	available ause of
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	18		30. Name and address of person who co		C*	. 1	Print)	= 23.	B	ALID &	mai a	1279		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Philip Russell Lindenmeyer 9, 2007 November 5:44 \mathbf{A}^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**X** M 2□ F Days Hours 220-46-8166 Director 55 February 4,1952 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with ind Mental Hygiene. marked other than "natural", or items 23a or 3 8316 Overmont Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify Specify: White à 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ING Insura Company Elementary/Secondary (0-12) College (1-4or 5+) Insurance Computer Analyst 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be fi Be Betty J. Heath Philip August Lindenmeyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,1 and 2 s f Health a Betty J.Lindenmeyer-mother 8316 Overmont Road-Parkville, Maryland 21234 Department of Heal Important: if item 2 any injury or other 20b. Place of Disposition (Name of EVANS FUNERAL CHAPEL Nov.11,2007 Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) AND CREMATIONS BEL AIR 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL CHAPPI, Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 1 ME andrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Amgorophy SCICLOSIS /Medical Due to (or a le conseque ce of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nor sequence of) Examiner physician and the burial-transit P.O. Box 687605 Due to (or as a consequence of): Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) the 9☐Unknown 9 ☐ Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No cate has been signated by page 2 should b 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐ No 2 **X**No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUSSEL 1 ☐ Yes 2 📉 No 3□ DOA 1 Inpatient ို 2 TER/Outpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

> State Registrar

Medical

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

6701 N. Charles St CHARIES M 32. Registrar's Signature

~m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36027 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** RUBY MAE LEIGH 0300 AM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death Examiner 4 imore 8. Date of Birth (Month, Day, Year) 7/07/1919 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 226-40-9086 1 □ M 2 💢 F 88 VIRGINIA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 No MD BALTIMORE Director GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1631 FOREST PARK AVENUE 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: BLACK 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7 Health and Mental Hygiene. em 27 is marked other than "r HECHT Elementary/Secondary (0-12) College (1-4or 5+) COMPANY RETAIL ASSOCIATE **7**TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT HENRY RYLAND HARRIET MEADE WHITFIELD or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau SHEILA LEIGH / DAUGHTER 1613 N. FOREST PARK AVE, BALTIMORE CO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 11/14/07 LARGO, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Enter the was ase, or complications that caused the poor or hear failure. List only one cause a each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest e Cause Final **Physician** heumom wee dis •••e or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD

Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

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31. Date filed (Month, Day, Year)

			State of Maryland / Dep		, ,					
			1 - State Registrar Ce	ertificate of Death	Reg.	N2007 36028				
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day A Year 3. Time of Death				
I.	/Medic		Marcial Martinez		Nov 3	3rd 2007 /2:11/4M				
7	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl		4c. County of Death				
			Prince George's Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Cheverly // If Under 1 Year If Under 24 Hrs.		Prince George's 9. Birthplace (State or Foreign				
	Funeral Director		215-71-5812 110 M 2 F 30 Yrs.	Months Days Hours Min.		Par) 1977 El Salvador				
	ס		Usual Residence of Decedent			23				
	rylan how	_	10a. State 10b. County 10c. City, Town or I	.ocation		10d. Inside City Limits				
	e Ma Ba-f s	cto	Maryland Prince George's Hyattsvi	11e		1 ☐ Yes 2 💆 No				
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	s 23s	era era	7206 E. Inwood Street	20785		El_Salvador				
_	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Ves 2 ☒ No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 	to Rican, etc.)	14. Race - American Indian, Black, White, etc.				
9500-512	ursaf al", or xam	þ	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☑ Yes 2 ☐ No Specify:	Salvador	Specify: White				
ڄَ م	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	16b	b. Kind of Business/Industry				
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baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ÅBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) cemetery, cr 0 a kwood 0		5/07	Bayshore, NY				
	ontar injur		21. Signature / Funeral Service Licensee	22. Name and Address of Facility						
ă	a m Del		Maren Grendle	Michael J. Grant F 571 Suffolk Ave.,	Guneral Hon Brentwood.	ne NY 11717				
	* =		23a. Part . Enter the disease, or complications that caused the death. Do not el speck, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	c or respiratory arrest,	Approximate Interval Between				
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):							
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X O	tendii r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery				
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>	ysicii is cer direct	o Be	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatie	Other		e 6 □Other (Specify)				
5	ng Ph fter th neral	i.T	27. Manper of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at	28d. Describe how in					
200	endli eath. or: A the fu	atic	2 Accident investigation	M 1 Yes 2 No						
<u> </u>	or Att fter de Direct in by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	t and Number or Rural Route Number, tate)						
ב	pital urs a eral [S	200 Cartifier	Allow a supposed at the street of the supposed by						
	e Hos 24 hc Fun etely	ledical	29a. Certifier (Check only one) Physician: To the best of my knowledge, dea (Check only one) Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	e, and due to the cause urred at the time, date	and place, and due to the cause(s)				
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)				
			1 Mulat	D52865	\ \	Vovember 3 rd 2007				
	2	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type			to the state of th				
			K. Michael Figero 3001 Hospital	l Drive Cheverly,	MD 20785					
	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 9 2007	while						
	Tee Still	-1	MITH A STORY							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lewis Sussex Morris, Jr. 05,2007 November 1:07 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 219 Division Ave. Lutherville Baltimore County 6. Sex ↑ M 2 F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 09, 1928 9. Birthplace (State or Foreign Country) Ridley Park, 1 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 79 Director Park, PA 204-22-0212 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore County Lutherville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 219 Division Ave. 21093 United States of Funeral <u>America</u> Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces? f=Yes 2 = No Korean If Yes, Give Year or Dates: Conflict Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than Insurance Agent A.A.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewsis Sussex Morris, Sr. Isabelle Kimports Condron P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 219 Division Ave. Lutherville, MD. 21093 Mrs. Janet Marie(nee Newman)Morris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Funeral Chapel Nov.09,2007 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) SFuneral Service License 21. Signatur 2 Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory *a*rrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trail Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Autops performed has certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 5 Residence 6 □Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA s after death.

I Director: After this of in by the funeral d After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 🔾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature of certifier 29d. Date signed (Month, Day, Year) 1141 rson who completed cause of death (Item 20a) (Type, Pri-

Registrar DHMH 17 Rev 1/2001

State

Name and address of

31. Date filed (Month, Day, Year)

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2007

32 Registrar's Signature

		For State Registrar		State of	waryiar		oartment of H e <i>rtificate of L</i>			ene g. No2	107	36	030
Physicia	an	1. Decedent's Name	t T. Mc	,		2			2. Date of Death November Day, 2007 7:54 P M				
/Medical		4a. Facility Name (/			ber)		4b. City, Town, or	4b. City, Town, or Location of Death			4c. County of Death		
Examin	er		st Center					owson		Balt	imore	9	
Funeral		5. Social Security N	Number 6.		7. Age (In yrs. 78		y) If Under 1 Year Months Days	'If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 27	Year)	9. Birth	place (State intry)	or Foreign
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with the a or 28s be noti	Funeral Director	7516 Ha	mber rford Roa	ь			10f. Zip Code	21234		g. Citizen of US		intry?	
death ms 23 must		11. Marital Status	LIOLU NO	12. Was Deced	dent Ever in U	J.S. 10	B. Was Decedent of Hill If Yes, specify Cuba			14. Ra	ace - Ameri	ican Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Marr	ried 2 X Married 4 □ Divorced	Armed Fore 1 X Yes If Yes, Give Year or Da	2 □ No		1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)	Spec.	ack, White, hify:	, etc. Vhite	
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atl		30. Name and addi	ress of person who	completed cause	of death (Ite	(23a) (Typ	e, Print)	arles S	7. Bal	to. n	nd Z	2020	×
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Baltimore, Maryland 21215-0036

NOVEMBER 8, 5:20 a.m.

Division or Vital Records, P.O. Box 68760, & ROBERT MELLICK

Robert Garber Mellick Robert Garber Mellick Robert Garber Mellick Robert Garber Mellick Robert Garber Mellick Robert Garber Mellick Robert Growth Member Show Baltimore Stella Maria Bospice S		1 = For State Registrar		Ce	rtificate of	Death	2. Date of Dea	giene Reg. No	2007	3603
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Table Tabl		Stella Mari	s Hospice		7	Cimoniu:	m		Balt	imore
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office 29e. Certifier (Check only one) 29e. Certifier 29e. Certifier 29e. Certifier 29e. Signature and title of certifier 29e. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of the second s	of death 5	Other (specify)		1 🔲 '	Yes 2[an osy ormed?	No 3 Pro	obably 4 Nunki topsy findings ava completion of caus
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner?	1 Live birth 2 Federate at time of 9 Unknown	of death 5	Other (specify) _	ven in Part I. 26. Place of De	24a. Was autoperfo	Yes 2[an an asy armed? 2 No	24b. Were au prior to c death?	obably 4 XUnki topsy findings ava completion of cause 2 No
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within 24 hours a To the Funeral I

State Registrar 2511 Edison Hwy., Baltimore, MD 21212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Lawrence Rubin, M.D.,

D37480

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day ncic **Physician** Month Year Muember 04 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner althorecity HOSPITA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/28/1959 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□¥ 579-86-8055 48 Washington, DC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at DC Washington 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 3603 17th Street NE 10f. Zip Code 20018 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 Is marked other the any Injury or other transmission. 18. Mother's Name (First, Middle, Maiden Surname)
Ernestine Leach 17. Father's Name (First, Middle, Last) Be John Miles 19a. Informant's Name/Relationship *(Type. Print)* Lauren Wells Daughter 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) 3603 17th Street NE, Washington, DC 20018 Lauren Wells 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/13/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter the discrete see, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 autopsy performed certificate 1 Yes **Division or Vital** 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural Injury 1 Tes death. 2 🗆 No 2 Accident 24 hours after death Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 23a) (Type, Print)

RES-000 November 4,2007

21287

Hospital 600 North Wolfe Street, Beltimore, Marylein a 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veniel 31. Date filed (Month, Day, Year) Hopkins 32 Registrar's Signature State NOV 0 9 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 October 16, 9:03 PM M Paul Martin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's St. Thomas More Nursing & Rehab Hyattsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Funeral 1 ☑ M 2 □ F Months Days Hours Min. Director 189-14-9159 Aug 8, 1921 86 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r 28a-f shov notified at 1 □ Yes 2√□ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 20010 USA 1824 Harvard Street NW by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ♥ Yes 2 □ No If Yes, Give Year or Dates: WWTT 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked any injury or after 27 is mark 1 ☑ Never Married 2 Married 1 ☐ Yes 2 No Specify white 3 ☐ Widowed 4 ☐ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 proof reader contracting 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Monahan/caregiver 2904 Bethany Lane Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other(Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 25a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships or heart failure. List only one cause on, ach line. Immediate Cause (Final **Physician** 0] disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 98 nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 vursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27 Manner of Death 28a Date of Injuny 29h Time of 29d Describe how injury occurred Certification:

To the Hospital or Attending after death. within 24 hours a To the Funeral C

1 □ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide	5 ☐ Pending investigation 6 ☐ Could not be determined	(Month, Day Year) Injury Work? Under M 1 Yes 2 ☑ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Subject Fell 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		Undnoun	Undnoun							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and	b. Signature and title of certified 2 and									

DO1852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Von

MA

October 18 2007 seensbury Rd My attrille Mil 2018

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 29d, 30 per drog 273 11/09/07dhb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOV. 2007 7:50AM MAJEL L. MORSEY 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 7859 Birmingham Avenue Baltimore Baltimore County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M X X F 401-42-9377 73 June 11,1934 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore County 1 ☐Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 7859 Birmingham Avenue USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 20 Married Specify: White 1 ☐ Yes X2X No Specify. 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking/Clerical Provident Bank 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Govenor Hoagly Womack Virgie Bond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter E. Morsey (Husband) 7859 Birmingham Avenue Baltimore, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XCremation 3 ☐ Removal from State Metro Crematory, Inc. 11-5-2007 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Lassann Funeral Home J. Lassehn 7401 Belair Rd. Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ulting in the underlying cause given in Part I. Other significant conditions contributing to death-but not res 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

> burial-transi and

attending physician for use as the buris

signed by the at d be detached for

been si should

page 2 s

this certificate

ospital or Attending Physician: I hours after death. uneral Director: After this certifical ly filled in by the funeral director, p.

To the Hospital within 24 hours a Hospital To the Funeral

certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Examine

Physician/Medical

þ

Completed

Be

Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

filed withir Hygiene.

12 should be filed w h and Mental Hygiel 7 is marked other tt

permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending investigation

28c. Injury at Work?

Other: 4 Nursing Home 5 Sesidence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7501 Osler Drive., Towson, MD 21204

29c. License number 1366

State Registrar

completely

31. Date filed (Month, Day,



6 ☐ Could not be



			State of Maryland / Dep 1- State of Maryland / Dep 1- State of Maryland / Dep Registrar	artment of Health and N	Mental Hygi	ene	000
	OR STATE		Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Death	2. Date of Death	3. Tim	ne of Death
	Physicia /Medic		BERNICE MASON		NOV. 0	Day Year 4 2007 2:	00P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
÷	Funeral	23	JOSEPH RICHEY HOSPICE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			N/A 9. Birthplace (Sta	ate or Foreign
	Director		229-48-0231 ^{1□M 2} ▼F 67 Yrs.	Months Days Hours Min.	02/22/	Year) Country) 1940 VIRGIN	IA
	laryiand show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Insid	e City Limits
	a-f sh	ctor	MD N/A BALTIM	ORE CITY		1 🕏	Yes 2□No
	with the	Dire	10. Street and Number	10f. Zip Code	10	g. Citizen of What Country?	
	ns 23	Funeral Director	110 N. CENTRAL AVE., APT. 320 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21202 Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	USA 14. Race - American India	٦,
2	after or Itel		1 Never Married 2 Married 1 Yes XXNo	If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 No Specify:	o Rican, etc.)	Black, White, etc. Specify: BLACK	
3	be filed within 72 hours after death with the Maryland Hylghen. die Hylghen dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 Wildowed 4 XDIVorced Year or Dates:	edent's Usual Occupation	1	Podry of Sends s/Industry	
212	hin 72 e. an "na Medic	Completed	(Specify only highest grade completed) (Given life.	e kind of work done during most of wor DO NOT use retired)	king	PLYSEAL PLAS	rics
7	led wit fygien her tha nt, the		12TH 1 G	ROUP LEADER		CORPORATION	
2	buld be filed with Mental Hygiene arked other than all event, the Market other than all event, the Market other the Market other than all event, the Market other	o Be	17. Father's Name (First, Middle, Last) JAMES W. WYCHE		ne (First, Middle, M SIA VIRG	INIA SYKES	
ai y	s 1 and 2 should be filed within 72 hours after death with the Maryla of Heath and Mental Hygiene at the first 23a or 28a-f show then 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ᅀ	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Ru			
, ·	1 and 2 Health em 27 i		AVERY MASON / SON 50	9 E. 41ST STREE			
5	Pages 1 nent of H int: If ite iry or ot		I Bullar 2 Spcremation 3 Li Removal from State	osition (Name of ematory or other place)		Oc. Location - City or Town, Stat	
	permit. Pages 1 a Department of Hes Important: If item any injury or othe			, , , , , , , , , , , , , , , , , , , ,		CATONSVILLE, UNERAL HOME	
ă	Imp any any		1 Mulling 18 Pourty	4600 LIBERTY HE	IGHTS A	VE., BALTIMO	RE, MD
			23a. Party Enter the dispesse, or complications that caused the death to not enshock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arre	st, Approx Interva Onset	imate I Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Carcinoma Due to (or as a consequence of):	of the Paux	rea 5	2 y	ears
	Examiner			•			
٠	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	al-tran	Examiner	that initiated events resulting in death) Last c				
0070	cate be executed ohysician and the burial-transit	dical E		V-44			
מא ממ	ertifica ling ph	Med	IF FEMALE:				
2	death c attend	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
į	at the c by the tachec	hysi	9 ☐ Unknown 9 ☐ Unknown				
ָה <u></u>	w requires that the death certific been signed by the attending p should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the causes s 2 □ No 3 □ Probably	
corns,	v requ	Completed			24a. Was an		
ב ב	The lay te has age 2	omp		-	autopsy perform	prior to completion death?	of cause of
<u>g</u>	sian: " ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Dea	1 Yes 2 ath (Check only one	XNo 1 □ Yes 2 □ No	
5	Physic this co	٦	1			nce 6 Other (Specify) Ho	spice
5	nding th. : After e funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident Investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
2	r Atter er dear rector by the	Certification:	3 Suicide 6 Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str City or Town	eet and Number or Rural Route State)	Number,
2	pital o urs aft eral Di illed in			Alexandra Albertine alexandra de la			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, dea (2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occ	e, and due to the ca urred at the time, da	iuse(s) and manner as stated. ate and place, and due to the car	use(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		Od. Date signed (Month, Day, Ye	
6			> Thed chtafed	D 14383	3	NOV 6 , 200	
P	Y		30. Name and address of person who completed cause of death (Item 23a) (Type Harold C Standiford	Joseph	Richey	Nov 6, 200 Hespice Mal	fimore
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	SEP.	1	•	
	Registr	LL I	RULLY HEM / HILL & ARGINES ST.				

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James W. Myer November 3, 2007 4:53 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mandrin Hospice House Harwood Anne Arundel if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☑ M 2 □ F 214-12-8387 86 Nov. 17, 1920 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ▼No r 28a-f sh notifled Maryland Anne Arundel Severna Park Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 330 North Drive 21146 ms 23a United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
uit: If fleau Z7 Is marked other than "natural", or items 23e into rite the traumatic event, the Medical Examiner must iny or other traumatic event, the Medical Examiner must. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: \$ 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Foreman State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. Myer, Sr. Marie Hament မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marie T. Myer / Daughter 330 North Drive, Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 6, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once, 4 □ Other (Specify) Lakeview Mem. Gardens 2007 Sykesville, Maryland 21. Sign fure of uneral S nice Licenses 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary ortern disease Physician /Medical Conjective heart farlers Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760,^c physician a the burial Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1□Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9∏Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 4 Probably 4 Unknown Hupertension Completed Lypullation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2X No Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4\square \, \text{Nursing Home}}$ $_{5\square \, \text{Residence}}$ 6 $\boxtimes \text{Other} \, (\textit{Specify}) \, \textit{Hospice}$ 1 Yes 2 No ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after the Funeral Dictor Completely filled in 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D33069 November 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Bernstein, M.D., 133 Defense Highway, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Reg. No. Reg. No. Cellificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Paul Physician Edward Miller Paul Edward Miller 05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital Center Rosedale

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) ocial Security Number 1 **Funeral** Months 1 □XM 2 □ F Maryland 5-02-1944 63 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County la or 28a-f show t be notified at 1 ☑ Yes 2 ☐ No Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 21214 "natural", or items 23a 5939 Bertram Ave. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify 3altimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dairy Products Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Edward Barrett Sr. Clara May Reden ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5939 Bertram Ave. Baltimore, Md. 21214 -Wife Miller Georgia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-09-2007 Maryland 4□Donation 5☑Other (Specify) Entombment Gardens of Faith 21. Signature of Funeral Service Licensee Gary R. DiGiovanna Name and Address of Facility Leonard J. Ruck Funeral Home Gara 5305 Harford Rd. Baltimore, Md. 21214 Deovannie Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ardiogen /Medical Due to (or as a control uence of): Card **Examiner** Sudden si any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ardiovascular The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months? ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Fis End-Stage Rena Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed sis dependent, Hyperlipidemia, Obstructiva 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation, Congestive heart failure 10 Yes performed. Sleep aprila, At 25. Was case _ ferred t _ edical examiner? 1 \(\text{Yes} \) 22 No 2 🗆 No 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) Be (Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death within 24 hours af er death. To the Funeral Director: A er Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of mamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner; sated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 0 9 2007

3 Name and address of person who mpleted cause of death (Item 23a) (Type, Print)

NNOCENT

Monya-Tanbi 9000 Franklin Square Drive Baltimure, Md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 6, 2007 **Physician** 02:00_{AM} M Julia Anne Marie Moran /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Hospital Center Carroll Westminster 8. Date of Birth (Month, Day, Aug 3, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) NY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2√2 F 076-56-7620 47 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltmore 1 Yes 2 No MD Resterstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Evanina and. USA 5407 Mt. Gilead Road 21136 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Program Specalist Social Security Admn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William P. Moran Elena Lohan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5407 Mt. Gilead Rd., Reisterstown, MD 21136 Mr. John C. Lotz (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 11/12/2007 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & Sykesville, MD 21784 P.A. (Box 195) 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 01905 Fis **Physician** ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yeş 2 ☐ No Month Year Day 4□Pregnant at time of death the 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ neta Static Carcinomo 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No 24a, Was an 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending Injury within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

 Q_{i}

29b. Signature and title of certifier

ENRICO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GANGER#50

"g" 2007

MD

200

MIS

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

MEMORIAL ALE, WESTMINSTER, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 05 Agnes Frances Marll 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ranklin Rosedale Baltimore 5. Social Security Number If Under 24 Hrs. & Sex Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 ☐ M 2 🔀 F 85 Director 217-18-9889 09/24/1922 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1105 N. Marlyn Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify ş Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed w Health and Mental Hygier om 27 is marked other the Stenographer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Wenceslaus Pete Agnes Anna Machovec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Philip George Marll - Son 914 Deer Court Abingdon, Maryland 21009 Baltimore, Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, 4 ☐ Donation 5 ☐ Other (Specify) Most <u>Holy Redeemer</u> 11/09/2007 Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee now 1407 Old Eastern Avenue chail Essex, Maryland 21221 23a. Part1. Enter the disease, or implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocard **Physician** /Medical as a consequence of) **Examiner** monar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examiner 0 physician ar s the burial-to Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f ☐ Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an h s was autopsy performed?
Yes 2 ANo page certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitals ပို 1 Yes 212 No Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) NGUYER 30. Name and address of person who cor ause of death (Item 23a) (Type, Print rive, Baltimore, m) 21237 9 OOD Fram 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Dep		Mental Hy	giene			
			Tregistral	ertificate of Death		Reg. No. 2	7 36041		
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	Day Year	3. Time of Death		
100	/Medic	al -	Thomas Francis McCarthy 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		er 6, 2007	6:00 A. M		
	Examin	er	Carriage Hill Nursing Home		ui	Montgome			
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)			rth 9 Ri	thplace (State or Foreign		
	Director		182-05-2218	Months Days Hours Min.	Jan. 27	7, 1918 Pen	o <i>untry)</i> nsy 1 vania		
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	ocation			10d. Inside City Limits		
	Maryla f sho led at	or	Maryland Montgomery Rockvill				1 □Yes 2X No		
	r 28a-	irect	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?		
	th with	al D	11801 Rockville Pike #706	20852-2721		United Stat	es		
	hours after death with the Maryland tural"; or Items 23a or 28a-f show al Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or Norto Rican, etc.)	o- 14. Race - Am Black, Whi			
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☒ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:					
5-0036	tural	ed k		edent's Usual Occupation			Specify: White 16b. Kind of Business/Industry		
2 2 2	hin 72 e. In "na Medic	Completed	(Specify only highest grade completed) (Gin	re kind of work done during most of wo DO NOT use retired)	orking		····,		
77	ed with	Som	12 Sales	sman		Business M	lachine Co.		
yland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle	e, Maiden Surname)			
<u> </u>	nouid d Men narke natic	은	Thomas McCarthy	Lillian					
<u>a</u>	d2sh thanc 7 is n traun			ling Address (Street and Number or R		, , , , , , , , , , , , , , , , , , , ,	- , ,		
<u>ရ</u>	Heal Heal tem 2			Waterview Court, consition (Name of ematory or other place) Nov.		d, Georgia 20c. Location - City o			
ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparatreent of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural; or Items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		I Bunal 2 Cremation 3 Hemoval from State	1	. 9, 007		•		
gaitimore,	mit. F portar oortar Injur			22 Name and Address of Facility.		Bethesda,			
ñ	a m m		M00896 7	557 Wisconsin Ave	., Bethe	esda, Maryla	and 20814		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	ac or respiratory a	arrest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition Acute Myocardial				Onset and Death 24 hours		
	/Medical Examiner		Due to (or as a consequence of):						
		Į.	Sequentially list conditions, if any, leading to kinnediate)isease			3 years		
1	uted d ansit	Examiner	cause. Chisease or injury that initiated events						
v D	exec an and rial-tra		resulting in death) Last Due to (or as a consequence of):						
8/60,	icate be executed physician and s the burial-transit	dical	d						
ة ×	ertifica ling pl	Med	IF FEMALE:						
X R R	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	Ill the past 12 months?	□Ectopic pregnancy		23d. Date of de Month	elivery Day Year		
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 5	Other (specify)			,		
7	that i		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute t	to the cause of death?		
ecords,	requires that een signed b nould be deta	d by	Urinary Tract Infection		10	Yes 2 No 3 ∏ F	robably 4 □Unknown		
ပ္သ	faw re as bee 2 shor	olete	Pneumonia		24a. Was	s an 24b. Were a	utopsy findings available		
T	The late ha	Completed			auto perfi 1⊟ Yes	ormed? death?	completion of cause of		
		BeC	25. Was case referred to medical examiner?	26. Place of De	eath (Check only				
2	Physician: this certific	으	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		Home 5□Res	idence 6 Other (Sp.	ecify)		
חכ	ling P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time Injury	Work?	28d. Describe	how injury occurred			
ISION	death ctor: / the 1	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - At home farms	M 1 Yes 2 No	28f Location ((Street and Number or F	Qural Pouto Number		
2	after Direction by	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	area, rustary, ornoc	City or To	wn, State)	idra Modie (Villiber,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	ce, and due to the	e cause(s) and manner a	is stated.		
	he Ho in 24 he Fu pletel	Medical	(Check only one) 2 ■ Medical Examiner: On the basis of examination and/or and manner stated.	Investigation, in my opinion, death occ	curred at the time	, date and place, and du	ue to the cause(s)		
	Veith Con To t	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)		
)	/		> Topap - Locdward	D17656		November 8	, 2007		
	15		30. Name and address of person who completed cause of death (Item 23a) (Type		1	1. 1.000	1.5		
	Sta	te	Tip Woodward, M.D., 5530 Wisconsin A 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	ve. #550, Chevy C	nase, Ma	ryland 208	15		
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	parket					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36042 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Wesley 12:00 PM Moran November 2007 06 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1086 Fitz Court Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 07 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F 213-26-1594 76 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Pasadena Anne Arundel Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21122 1086 Fitz Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold Moran Mildred Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1086 Fitz Court, Pasadena, MD 21122 Betty Moran (spouse) Nov. Date 07 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) Stallings Funeral Home, P.A. 21. Signature of Funeral S 22. Name and Address of Facility 3111 Mountain Road, Pasadena, Md 21122 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

iral", or items 23a or 28a-f sh Examiner must be notified

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Medical Examiner must be no once.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

2

the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 6876000

Immediate Cause (Final disease or condition resulting in death)	a. So Due to (or as a consequence of):	d Carcino	nd	Onset and Death						
Sequentially list conditions, it my later to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b									
resulting in death) Last	CDue to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23b. Was decedent pregnant in the past 12 months? 1									
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	s contributing to death but not resulting in the underl	lying cause given in Part I.	24a. Was an 24b. Were	Probably 4 Unknow autopsy findings availab to completion of cause of						
25. Was case referred to medical examiner?		26. Place of Death		74						
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Othor	me 5 Residence 6 □Other (S	Specify)						
27. Manner of Death Matural 5 ☐ Pending 2 ☐ Accident investigat	OII	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred							
3 Suicide 6 Could not 4 Homicide determine		factory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,						
	Physician: To the best of my knowledge, death occ aminer: On the basis of examination and/or investi and manner stated.									
29b. Signature and title of certifler		29c. License number	29d. Date signed (M	onth, Dav, Year)						

DHMH 17 Rev 1/2001

5

Registrar

State

within 24 hours after death To the Funeral Director: completely filled in by the 1

29b. Signature and title of certifler

Date filed (Month, Day,

Year)

NOV 0

9 2007

npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08404 State of Maryland / Department of Health and Mental Hygiene 2007 36043 Stephanie Lee Newsome Certificate of Death 1- For State Reg. No Time of Death Registrar 2. Date of Death ecedent's Name (First, Middle,Last) Physician/ Stephanie Month Day October 28, 2007 2237 hrs Lee Newsome **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Mount Ranier 3113 Perry Street If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex **Funeral** 5. Social Security Numbe 229-92-1087 Hours Min Days 2XF Months Country) 01/03/1965 Director 42 M Usual Residence of Decedent 10d. Inside City Limits 10b.County Prince George loc. City, Town or Location any 0a. State MI) Mount Ranier 1 X Yes 2 MD ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 3113 Perry Street 20712 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Armed Forces' 2 Married Yes Specify: Black 2X No specify: Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after a
Department of Health and Mental Hyggene.
Important: If item 27 is marked other than "natural", o
injury or other traumatic event, the Medical Examiner in If Yes, Give Year Divorced Widowed 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeping Hote1 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Jimmy Newso N. Riddick Newsome Shirley Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Clarine Daniel, Aunt 3113 Perry Street 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition

1 X Burial 2 Cremation 3 Removal from State Pinewory Orbove dac Church 11/02/2007 Newsoms Virginia Donation 5 Other Specify 22. Not and indress of Facilities Funeral Schuce 5151 Batto. Nat 1 Pile, Batto., MD 2 21. Sig ature of Fur s al Service License mo 21229 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death a. Acute ethanol intoxication complicating seizure disorder 'Medical Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit certificate be execu Physician/Medical X AMENDED 27,28a-f. X UNPENDED perME.g873, 11/14/07 TT physician the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IE EEMALE: Day Year Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 requires that the death 1 Yes 2 No 9 V Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Diabetes mellitus Completed 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy death? performed? The law 1 🗸 Yes No Yes 2 No this certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Other₄ Nursing Hame 5 Residence 6 Other: Scene Hospital: DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2 y No Natural unk Pending Director: d in by the f FNd 10/28/2007 FNd 10:18 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be or Town, State)
3113 Perry St. Mt. Rainier, MD Suicide To the Hospital o within 24 hours af To the Funeral D determined house Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 29, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Ana Rubio MD.

31. Date filed (Month, Pax.

2007

Assistant Medical Examiner

32 Registrar's Signature

A STATE OF THE PARTY OF

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #10f Per FH G873 11/09 60 Tickle of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month V O V **Physician** Passalacqua Dilvio 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Belair Health and Rehabilitation Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda BelAir Harford 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**M**M 2□F Country) Months Days Hours Min. 215-10-4789 Director 18,1900 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 No Harford Completed by Funeral Director Mariland 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 21015 Ital 503 Store items 23a Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 5 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates: er than "natura", the Me ical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Construction NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Domenica Lambardi 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Passa Gagna (Niece 502 Old Store Place Bel Air MD Elissa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: if ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nev 8, 2007 Evans Funeral Chapel Forest Hill Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility & Cremation Services - Bel Air Event's Even's Even's Even's Even's Ev 21. Signature of Funeral Service Licenses 3 Newport Drive Forest Hill Maryland Je 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset/and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner eer S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Silvio, Passalacqua Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Par/H. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has e 2 r this certificate has autopsy 2X No 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 20d. Date signed (Month, Day, Year) 29b Signature and title of certifier of death (Item 23a) (Type, Print

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician November 2, 6:45 PMM Gerard John Poetzel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 4, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F Mary Tand 66 **Director** 213-36-3033 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Middle River Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21220 USA 113 Cowhide Circle Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed 4 🂢 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) un. 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) the knife sharpener 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi h and Mental F 7 Is marked otl Be Karl A. Poetzel Magdalen Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If them 27 Is n any Injury or other traum Alice Smith/friend 113 Cowhide Circle Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation _5 Q Other (Specify) 21. Signature of Euneral Privice Licensee Roll and S. Wade. ^{22. Name and Address of Facility} State Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arrhosis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? res 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Flother (Specify) NO 1914 Hospital: 2 **/ ()** 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral To the Hospital or Attending

N Chorles St Tower no 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Commiss un 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2007 Registrar **ORIGINAL**

29d. Date signed (Month, Day, Year)

November 2 2007

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician PLAIN OLIVER OCTO BER 9:58 PM 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKING BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Director 216-28-6467 75 Aug 10, 1932 Maryland Usual Residence of Decedent 10h. County 10c. City. Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 other traumatic event, the Medical Examiner must be 21221 USA 939 Arncliffe Road or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by Specify Specify: white If Yes, Give Year or Dates: 149–54 3 ☐ Widowed 4 ☐ Divorced "neturel" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 installer carpeting/windows 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Earl Plain Fertetta Nellie Marie McClelland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Jean Plain/spouse 939 Arncliffe Road Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it eny injury or c once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Sign ture of Fun. of Service Licensee Ronald S. Way 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Pakt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner CHEOMIC OBSTRUCTIVE PULINOHARY DISEASE and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medicai as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No a∏Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of has death? 1 ☐ Yes 2 No 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA P this 1 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be

death certificate be executed Records, The law Division or Vital To the Hospital or Attending Physician:

filed within 72 hours after death with the Maryland

should be

Maryland 21215-0036

Baltimore,

0

in by

after death. within 24 hours a

State Registrar

31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a. Certifier

cai

medical resident

and manner stated.

RESOOI

29d. Date signed (Month, Day, Year)

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

OCTOBER 31

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMMANUEL GOROSPE, MD JOHNS HOPKINS BAYVIEW MED CTP. 4940 EISTERN AME BOILTIMONE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

NOV 0 9

tle of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar		State of	Maryla		artment of F		and Mental Hy	giene (07	36047
۳			Decedent's Name (F							2. Date of De		Year	3. Time of Death
ı	Physici: /Medic		Norma M.	Parkei						Novembe		2007	1:50p M
	Examin		4a. Facility Name (If no					4b. City, Town, o		f Death		unty of Death	
			Transitio				land hintheless	Sykes If Under 1 Year		24 Hrs Date of Bi	Car		Jane /State or Foreign
	Funeral Director		5. Social Security Num 219-05-941	1	M 2007F	. Age (iii yi:	s. last birthday, Yrs,	Months Days	Hours	Min. 8. Date of Bir (Month, Date of Bir Oct 28	1919	Cour	place (State or Foreign ntry) MD
			Usual Residence of De							DCL 20	1717		TID
	arylan show			ob.County Baltimore	2		ity, Town or L .1timore					1	0d. Inside City Limits
	Ba-f s	cto				Da	T CIIIOI (1 ☐ Yes 2 TNo
	th with t	Funerai Director	6143 North		ad			10f. Zip Code 21228			10g. Citizen of What Country? USA		
36	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "naturel", or Iteme 23e or 28e-1 show event, the Madical Exertical is instituted at	by Fune	11. Marital Status 1 Never Married X Widowed 4 [12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	dispanic Original dispansion of the dispansion o	gin? (Specify Yes or No , Puerto Rican, etc.)		Race - Americ Black, White, ecity: whi	etc.
9	2 hou	ted	15	5. Decedent's Edu	cation		16a. Dece	dent's Usual Occup	pation			of Business/In-	
1215	within 7; ne. hen "n	Completed	(Specify Elementary/Seconda	only highest grad ary (0-12)	College (1,4or 5+)			kind of work done DO NDT use retire nistrativ	d)		State of Maryland		
d 2	filed v Hygie other i	a)	17. Father's Name (Fir						,	r's Name (First, Middle	i		
Baltimore, Maryland 21215-0036	2 should be filed v n and Mental Hygie le marked other t raumatic event, ID	To B	George Par	ker					Gert	rude Daviso	on		
	ges 1 and 2 should t of Health and Mer If item 27 le marke or other traumatic		19a. Informant's Name Lynn M. Ma	1, 1, 1						ror Aural Route Numb r., Sykesvi			
	of Her		20a. Method of Dispos 1 ☐ Burial 21 🛱 C		Removal from S	- 1	Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date		ion - City or To	
<u><u><u></u><u><u></u><u></u><u></u></u></u></u>	Pag ment tant: I		`4 □Donation 5		temoval nom o	A1		ty Cremat			-	ville,	
Ball	permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other tra		21. Signature of Funer	ral Service Licens Joingly O		t				^y Haight Fur kesville, N			Chapel
8760, 2	/Medical Examiner the purial-transit	ai Examiner	23a. Parti. Enter the shock, or heart from the shock, or heart from the shock, or heart from the shock, or heart from the shock of the	tions,	Due to (c	r as a conse	equence of):			cardiac or respiratory a	0 1) Ŋ	Approximate Interval Between Onset and Death
P.O. Box 687	the death certifi y the attending ched for use as	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1						у		23d. Date of delivery Month Day Year		
	uires tha signed Id be del	by	Part II. Other significa	nt conditions co	ntributing to dea	ath but not re	esulting in the i	indertying cause giv	en in Part I.		tobacco use Yes 2 □ N		he cause of death? pably 4 Junknown
Vital Records,	The law requires that ate has been signed be page 2 should be deta	Completed								24a. Was auto perfi 1 Yes	psy primed?	24b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred examiner?	_						of Death (Check only	one)		
	Physi this c	2	1 □ Yes 2 □ No				☐ ER/Outpatie		4 1	rsing Home 5 Res			(y)
n (ing After une	tion		5 Pending	28a. Date of (Month	, Day Year)	28b. Time o Injury	Wo	ryat rk? Yes 2. □	28d. Describe	now injury or	ccurrea	
Division of	or Atten fter deat Sirector: in by the	Certification	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	28e. Place o	of Injury - At g, etc. (Spe	home, farm, si	reet, factory, office	103 2	28f. Location	(Street and N wn, State)	lumber or Rura	al Route Number,
	To the Hospitel or At within 24 hours after corpletely filled in by completely filled in by	edicai Ce	29a. Certifier 1[(Check only 2[Gertifying Phy	sician: To the b	oest of my k	nowledge, dea	th occurred at the tile	me, date an	d place, and due to the	cause(s) and	d manner as s	tated.
	thin 2 the l	Med	one) 29b. Signature and titl	a of certifier	and manne	er stated.		29c. Licens	se number		29d. Date s	igned (Month,	Dav. Year)
ł	T W D		D P	100	mo	ug		DC	05	4218	11-1	7-20	07
	12		30 Name and address	of person who co	. Kar	reng	em 23a) (Type 349	Print) Cal	m D	4218 nive, Wes	fmin	sty MD	21157
	Sta Registr		31. Date filed (Month,		07 32 Ae	gistrar's Sig	nature	ade					

1. Decedent's Name (First, Middle, Last)	
Physician /Medical BILLY JACK POOLE	2. Date of Death Month Day Year NOVEMBER 7, 2007 4:50 A 4:50 A
Street 4a. Facility Name (if not institution, give street and number) 337 Catherine Street Funeral Director 5. Social Security Number 6. Sex 1 T. Age (In yrs. last birth) 71 Yr	Bel Air Harford Ay) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day Year) 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Decedent 10a. State 10b. County 10c. City, Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. City Town of Decedent Bell Air 10c. Cit	r Location 10d. Inside City Limits
The policy of th	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: Specify: White decedent's Usual Occupation 16b. Kind of Business/Industry
S S S S S S S S S S S S S S S S S S S	nner/Estimater 18. Mother's Name (First, Middle, Maiden Surname) U.S. Government
	Sarah Ielia Murphy ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Street, Bel Air, Maryland 21014 sposition (Name of trematory or other place) Date 20c. Location - City or Town, State
20a. Method of Disposition 1	Memorial Grdn 11-9-07 Fel Air, Maryland 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009
/Medical resulting in death) Due to (or as a consequence of)	enter the mode of dying, such as cardiac or respiratory arrest, NCEN Approximate Onset and Death
resulting in death) Last Due to (or as a consequence of)	DEMIA
	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year
et tie de	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
The large of the l	24a. Was an autopsy findings available prior to completion of cause of death. 1 Yes 2 No 26. Place of Death (Check only one)
25. Was case referred to medical examiner? 1	tient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	City or Town, State)
29a. Certifier 1 Certifying Physician: To the best of my knowledge and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Ty SYED F MAHMOO) 2227 OLD State Registrar NOV 0 9 2007	D45921 NOVEMBER 7, 2007 HARYLAND 21015 EMMORTON ROAD SUITE 212 BEL AIR

Terrence Regan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 36049 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2007 2252 hrs Medical Examine TARRENCE MAURICE REGAN-BURWELL 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number N/A Baltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign MARYLAND Months Day: Hours Min Director 1XXM 2 F Yrs 0/03/1991 218-33-1453 16 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 1 XYes 2 No 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not injury or other traumatic access to the properties of t BALTIMORE MARYLAND N/ADirector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 499 BEAUMONT AVENUE APT 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1XX Never Married 2 X No Yes Specify: BLACK Yes 2 XX No specify: If Yes, Give Year Divorced Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) REGINAL F. LEWIS STUDENT HIGH SCHOOL 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TAMALA REGAN KIRK MITCHELL (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Μđ 21212 Tamala Regan/Mother Beaumont Ave., Apt B4. Balto. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State 1 X Burial 2 WOODLAWN CEMETERY 11-13-07 BALTIMORE, MARYLAND Sonation 5 Other Specify 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. nature of Fugleral Service License 1206 W NORTH AVE. iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or co Physician Between Onset and failure. List only one cause of Death Medical a. Gunshot wounds (2) to torso and head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical X AMENDED UNPENDED attending physician or use as the burial -,perME,g873, 11/9/07 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Į, 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by t I be detache Part II. Other significant conditions o Yes 2 ✔ No 3 Probably 4 Unknown à Records, P. Completed 24b. Were autopsy findings available 24a. Was an After this certificate has been funeral director, page 2 should prior to completion of cause of autopsy performed? death? No ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificompletely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be Other, Hospital: Residence 6 Nursing Home 5 2 V ER/Outpatient 3 Inpatient ٩ 1 ✓ Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28b. Time of Injury 27. Manner of Death Subject shot Certification: FOUND: Yes 2 V No 1 Natural Pending 2210 hrs Nov 5, 2007 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 1600 block Lochwood Road , Baltimore , MD Suicide (Specify) Local Street 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 6, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD 31. Date filed (Month, Day, Year) Registrar's Signature 32 State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year FITES VAUIO マベス NOU 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bouch Parkville Parkwa | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 3 • 2 5 • 1 9 1 6 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 2 4 2 □ F 216.03.8712 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8405 A Nunley Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Rites Florence Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8405 A Nunley Drive Parkville, MD
e of Disposition (Name of Date 20c. Location - City or Town, State Marlene Patrick/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 11.09.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee 101443 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac Anthonia disease or condition resulting in death) Due to (or as a consequence of) Dehydraha Due to (or as a consequence of) Due to (or a a configuence of): CUA IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

nding physician and use as the burial-tran

ned by the a

page 2

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Be

Medical Certification: To

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Examiner

Department of Health ar Important: If Item 27 Is any Injury or other trau

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be r

the

Director

Funeral

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Completed

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MD

death with the Maryland

filed within 72 hours after Hygiene.

s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical

Vicheles

24a. Was an autopsy performed?

28d. Describe how injury occurred

1 Yes 2 No 3 Probably 4 Unknown

26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify)

70 vson

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 116 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Hospital:

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

CAD

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 31295

29d. Date signed (Month, Day, Year) 11/8/02

3

State

Registrar

Kluesz 31. Date filed (Month, Day, Year) NOV 09

Challes 6701 N 32. Registrar's Signature

Sut 4202

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No U Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day **Physician** HARO BERNAMO 10:30 AM November 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/ABALTIMORE HOMEWOOD GENGSIS CENIZEN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**½** M 2□ F 217-56-2365 Maryland Director 1951 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Baltimore 1 TyYes 2 □ No Maryland N/ADirector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 727 Druid Park Lake Drive Apt.4L Pages 1 and 2 should be filed within 72 hours after death with 21217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, et Black ☐Yes 3☐ No Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) \$elf-Employed Landscaping 9th_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Bernard Reed, Sr. 19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zip Code) 2821 Santa Fe Avenue Baltimore, maryland 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trac Lashae Poyner/Daughter <u> 21215</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 11/10/07 20a. Method of Disposition 20c. Location - City or Town, State Lansdowne, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Paneral Service Licen o ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RECTAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and physician an s the burial-tr Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 🗆 No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 ⊟Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No Director: 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours at To the Funeral E completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier ATTONDING 29d. Date signed (Month, Day, Year) 20062239 PHYSIC IAN NOVEMBER 2 2007. NACHE OD, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DL MAW 5. Sura 4202 Towson MD CHARLES NORTH 32 Registrar's Signature 31. Date filed (Month, Day, Year) (parte) State 2007 CARLAR S Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:40 A M Rosmus Elizabeth Marie /Medical November 6,2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Riverview Nursing Home Baltimore Co. Essex
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 85 199-10-4511 Director Dec. 25,1921 Pennsylvania Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits ns 23a or 28a-f shor must be notified at 1 ☐Yes XXNo Director Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 103 Center Place Apt. 113 21222 United States Completed by Funeral ıral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White "natural", other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Yéars Assembly Line Worker Glass Factory 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Rosmus Mary Holota ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai once, Frances Casto (Niece) P.O. Box 99 Townsville, NC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/12/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signative Juneral Service Licensee 22. Name and Address of Facility Duda-Ruck funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner signification if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner tension The law requires that the death certificate be executed burial-tran Due to (or as a Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed?
Ves 211 No has page 2 certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ted cause of death (len 23a) (Type, Print)

Compared to the co 30. Name and address of person who compl Baltimore <www. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elizabeth Clara Riedel November 7, 2007 12:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. Director 88 138-18-4374 1919 New York July 1, Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or items 23a or 28a-f shov dical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6210 Madawaska Road death v 20816 Funeral United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: 3 Nidowed 4 Divorced White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f ATYN.

1 and 2 should be of Health and M.

7 Town 27 is Chester Earl Morris Elizabeth Paula Goethel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise R. Lewis / Daughter 6210 Madawaska Road, Bethesda, Maryland 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages 'nent of hant: If ite Potomac United Methodist 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery Nov. 13, 2007 | Potomac, Maryland 21. Signature of Funeral Service Loansee Robert A. Funishirey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, Maryland 20814 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat y arm List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Subdural Hematoma Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, physician 0 requires that the death certificate be Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No Ö ed by the detached 9 Unknown 9 Unknown مَ signed of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy page certificate 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☒ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 \ No 2 ER/Outpatient 3□ DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending subject Oct. 18, 2007 14:00 To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation death. 1 ☐ Yes 2 1 No 2 Accident tripped and fell 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5, denalt 4925 Battery Lane Bethesda, MD 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

Atul Rohaltgi, M.D., 8600 01d Georgetown Rd., Bethesda, Maryland 20814

s of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

Sept Sent

D0061302

November 8, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 04 Michael J. Raitch 2007 Növember 9:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pear Tree Assisted Living Pasadena Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 01 Birthplace (State or Foreign Country) Months Days Hours ^{Year)} 1908 1 ☑ M 2 ☐ F 159-18-9182 99 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐Yes 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1358 Jamestown Drive 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 → No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Solider United States Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore J. Raitch Mary Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore R. Raitch Sr. (brother) 1358 Jamestown Drive, Severn, MD. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem Crownsville, Maryland 21. Signatury of F 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can see an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STroke week Due to (or as a consequence of): antensa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 2 No

Physician /Medical Examiner

permit. Page Department o Important: If any injury or

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed

and burial-trar attending physician for use as the buria ned by the a signed l cate has been signated bage 2 should be certificate

Examine Physician/Medical ≥ Completed Be ျ Certification:

After t filled in by the Medical

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

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State Registrar

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

203 HOTHITAL Sine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0-0. 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day WILLIAM FRANKLIN REED JR. NOVEMBER 6, 2007 2:30 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONUIM BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 137 M 2□ F 218-40-7673 64 18, 1943 Maryland Mar. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2X No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3807 Walters Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Box Manufacturer 12 Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Franklin Reed Sr. Ruby Belle McClure 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Jean Reed / Wife 3807 Walters Rd., Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11-8-07 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Russ 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. FSOPHAGEAL CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a Was an

Physician /Medical Examiner Examine

permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other

Physician

/Medical

Examiner

Director

Funeral

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"natural", or

the Maryland

Maryland

Baltimore,

use as the burial-tran physician

Physician/Medical

Completed by

Be

Certification:

or Vital Records, P.O. Box 68760,

Division

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1□ Yes 2X No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 👿 No 27. Manner of Death 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year)

and manner stated

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

4 Homicide

29a. Certifier

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD 31. Date filed (Month, Day, Year)

NOV 0 9 2007

32. Resistrar's Signature

2300 DULANEY VALLEY RD.

State

Registrar

			Please Type or Print in Black Indelible Ink. Ensure All	•	
			1- State of Maryland / Department of Health and Me Registrar Amend Item 8 per fh, 8878, 04/11/08dhb of Death	ental Hygier Reg. F	2007 36056
	Physic /Medi		Mary K. Roat	NOV	Day Year 8:55 PM
	Exami	ner	4a. Facility Name (If not institution, give street and number) Althea Woodland Nursing Home Silver Spring	MDI	Montgomery CO.
	Funeral			8. Date of Birth Month, Day, Yes 03/08/19	
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	03/08/19	20 Canada 10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Medical Exprendent must be notified at	Completed by Funeral Director	MD Montgomery ca Takoma Park		1 XYes 2 □ No
	h with	al Dir	6505 Kansas Lane ATIA 70912	log. (Citizen of What Country?
	er deat	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
980	ours aft ral', or Exemi	l by F	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give Year or Dates:		Specify: White
21215-0036	n 72 h	oletec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g 16b.	Kind of Business/Industry
212	filed withi Hygiene. other than	Comp	12yr College (1-4or 5+) 12yr Crthotist Assistant		Trivate
Maryland	2 should be filed within and Mental Hygiene. is markad other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (Martha	(First, Middle, Maid	en Sumame)
lary	2 should I and Meni is markar	J.	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number, Cit	or Town, State, Zip Code)
	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tre once.		20a. Method of Disposition 20b. Place of Disposition (Name of Da	APT A	Location - City or Town, State
imo			1 Burial 2 & Cremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State Riverdale Rivk Cremitary 11-8-	. ~ 0	verdale MD.
Baltimore,	permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hackett's Funeral	Chape	814 Upshur St N.W. Weishington DC.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Arthuroscipenotic Candidate Cause (Pinal disease or condition resulting in death) Due to (or as a consequence of):	lan Dist	ase years
	Examiner	-	Sequentially list conditions, Laux leading to properlies.		
7	outed Id ansit	Examiner	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
,092	ite be executed lysician and ne burial-transit	cal Exa	resulting in death) Last Due to (or as a consequence of):		
9	tificate ng phys as the	fedic	d.		
Вох	eath certificate attending phys for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the de ted by the a detached t	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		
	9 P P P	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
ecor	e law requir has been si ge 2 should I	Completed	Dysphalla	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al R				performed	death?
f Vit	ys dis	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		6 ☐ Other (Specify)
o uc	ling Ph t. After th tuneral	L:uol	27. Manner of Death 1 🗀 Natural 5 🗆 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 38b. Time of Injury	ld. Describe how in	
=	or Attending after death. Diractor: After in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify) M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
	Hospital 4 hours a Funeral ely filled	edical Ce	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred		
	To the P within 2 To the F complete	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d. [Date signed (Month, Day, Year)
			Pemblinelleren DO1852	No	vanber 8 2007
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A DEVOLE MA 4203 (Type, Print) Paul A DEVOLE MA 4203 (Type, Print)	Hypites	vanber8 2007
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Julius B. Squires 05, 2007 4c. County of Death (alewpose 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) VA Maryland Health Care STEM Perry Point JEC1 If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) Days 1**X** M 2□ F 239-22-4081 84 Sept.20,1923 NC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo MD Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 633 Falconer Road 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 21K No 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Standard Enameler 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rena Lee Sherman Squires 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cynthia Wickenheiser 633 Falconer Road Joppa Md 21085 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 11/9/07 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Pa 11. Enter the disease, or om sh ck, or heart failure. List nly Immediate Cause (Final disease or condition resulting in death) Kespiratory **UNKNOWN** Due to (or as a conseque ce of): hranic Obstructiv Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Jnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar by After t n 24 hours after death.

ne Funeral Director: Af

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

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Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

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Funeral

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At hom building, etc. (Specify) At home, farm, street, factory, office 4 Homicide 1× Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

29c. License number

within 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

th Care:

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend PI, line a-b, 28b, perME, g873, Certificate of Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:02 PM Michae Smith 200 ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Manhard Medical Center University 0. BALTIMORE CITY 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☑ M 2 ☐ F 219-92-745 4, Director 1973 WISCONSIN DEC. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 ☑ No notified Director MARYLAND ANNE ARUNDEL PASADENA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö must be 23a UNITED STATES 21122 214 MOUNTAIN RD. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 Is marked other than "natural", or items traumatic event, the Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4 X Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. CONSTRUCTION CONTRACTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ပ CAROL HEMSTREET STUART KENT SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any Injury or other trau MD 12615 KILBOURNE LANE BOWIE, 20715 CAROL MILLER / MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition NOV. 7, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 2007 ELKRIDGE, MARYLAND MEADOWRIDGE MEM. PARK 21. Signative of Full rail Se 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. ice Licensee 421 CRAIN HWY. SE; GLEN BURNIE, -21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple injuries with complications My MEDICAL PRIMINER Immediate Cause (Final disease or condition resulting in death) Physician hours /Medical Due to (or as a consequence of): 7 hours Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown been signed by a should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to ∞mpletion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy nerform certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1XInpatient 2 ER/Outpatient 3 DOA မှ After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1611 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending ATV accident 1 ☐ Yes 2 🗷 No 11/03/2007 investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide nome ō 214 Maurtain Read Pasadena, MD Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16781 2001 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 22 S. Greene of general Suigery 2123 Dept Stump MD egistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

07-08605

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 36059 Falarin Sofowora Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2007 1511 hrs ral Examiner Folarin Sofowora 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Country) Hours Min. Months Davs Director 1/23/2001 2 F 1 X M 5 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No or 28a-f show Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21214 2314 Ruckert Ave. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death valuent of Health and Mutall Hygiene.
ant: If item 27 is marked other than "natural", or item
or other traumatic event, the Medical Examiner must b 1 X Never Married 2 Married SpecifyBlack Yes 2 X No specify: If Yes, Give Year Widowed Divorced 4 ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed I College (1-4 or 5+) Elementary/Secondary (0-12) Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Victoria Thomson Be Olanrewaju Sofowora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore MD 21214
Date 20c. Location - City or Town, State ner 2314 Rueckert Ave 20b. Place of Disposition (Name of cemetery, Olanrewaju Sofowora/Father 20a. Method of Disposition 20b. F ltimore, crematory or other place) or other 1 X Burial 2 Cremation 3 Removal from State rmel Cemetery 11-10-0 Baltimore, MD
2. Tame and Address of Facility Fonal aylor II F Donation 5 Other Specify: 21. Ignatur of Funeral Service Licens 21201 108 W. North Ave. Baltimore, Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ,Physician failure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial -23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Year Month Day 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Ö signed by the detach 1 Yes 2 No 3 Probably 4 Unknown þ Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? this certificate has 1 🗸 Yes Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Division of Vital Be Other₄ examiner? Residence 6 Other Inpatient 2 V ER/Outpatient 3 1 V Yes 28a. Date of Injury After thi funeral d 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject passenger in vehicle involved in motor Certification: Nov 5, 2007 1441 hrs Yes 2 V No Natural vehicle accident Pending Director: the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 6000 block of Hillen Road, Baltimore, MD Suicide determined (Specify) Major Road / Highway To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier **OCME** November 6, 2007 O.C.M.E. leted cause of death (Item/23a) address of perso 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD 31. Date filed (Month, Day, Year, NOV 0 9 32 Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registra

ORIGINAL

2007

07-08582 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Margaret Stringfellow State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 4, 2007 Stringfellow 1155 hrs Medical Examiner Ann Margaret 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 3401 St. Ambrose Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Country) Months Davs Hours Min Director 35 SC 09 01 217-38-4602 М 2 X F 72 Usual Residence of Decedent any 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 No NA or 28a-f show MD , or items 23a or 28a-f shorr must be notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code l0g. Citizen of What Country? 21215 U.S.A. 3401 St. Ambrose Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o
injury or other traumatic event, the Medical Examiner: 3 X Widowed 4 Divorced If Yes, Give Yea Yes 2 No specify: Black ģ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Visiting Nurse Elementary/Secondary (0-12) College (1-4 or 5+ Certified Nurse Assit. 12th grade na Assoc. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Pompey Be Louise Henry Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 2110 Friethorn Road,, Middle River, Cynthia Robertson-Daughter 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) 11/10/07 Baltimore Co, Woodlawn Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
March F/H West 21215 Md 300 Wabash Ave, Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and allure. List only one cause on each line /Medica Death a. Atherosclerotic Cardiovascular Disease ediate Cause (Final disease Examiner condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Day Live hirth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months' Pregnant at time of death 5 Other (Specify) for 1 Yes 2 V No 9 Unknown q Unknown i signed by the a d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si, , page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? certificate Yes 2 V No Yes 2 To the Hospital or Attending Physician: within 24 hours after death. director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other; ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this Inpatient ဥ 1 V Yes funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: ✓ Natural Yes 2 Pending To the Funeral Director: the 2 Investigation Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a, Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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OCME 2006

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifie

Jack Titus MD.

31. Date filed (Month, Day, Year,

and manner stated

Deputy Chief Medical Examiner

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 5, 2007

29d. Date signed (Month, Day, Year)

Md

No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Lowell Stevenson Jesse 2007 :15a 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Brook Health & Rehab Montgomery Silver Spring If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**☐ M 2☐ F 242-42-1805 76 Director NC 02 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ia or 28a-f show t be notified at 1 ☐Yes 2 ☑No Director Bowie MD Prince Georges 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 20720 U.S.A. "natural", or items 23a 10417 Vista Garden Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Bar Owner 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filk ment of Health and Mental Hiant: If item 27 Is marked oth Be Rosa Pruvis Sam Stevenson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10417 Vista Garden Drive, Bowie, Md 20720 Barbara Parks-Daughter item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any Injury or conce. Garrison Forest Vet 11/13/07 Owings Mill, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee Ec ille 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multi Organ Failure Weeks /Medical Due to (or as a consequence of): Examiner End Stage Renal Disease Due to (or as a consequence of): Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; physician Physician/Medical th. ass IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Arteriosclerotic Disease autopsy performed? has e 2 page certificate Congestive Heart Failure Physician: 25. Was case referred to medical examiner? rector, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ ö this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation Hospital or Attending Natural Injury the Funeral Director: After Andreigh filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ٥ 6 11/7/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KX R. Perry Street, Mt. Rainier, Md 20712 32. Registrar's Signature 3503 Raman Tuli 31. Date filed (Month, Day, Year) State

ÖRIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Robert Henry Sch		er - For State	St	ate of Mary	land / [ment of <i>icate of</i>		l Menta		Reg. No.		07 3608
Physicia		tegistrar 1. Decedent's Name				-				2. Date of De	eath	Year	3. Time of Death 0933 hrs
Medical Examir		ROBER			HRIE	BER,		b. City, Town, or L	ocation of	Novemb	er 8, 20	007 c. County of Deat	
2		4a. Facility Name (if 3609 Foster		on, give street and	number)			Baltimore	20021101101			N/	'A
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days		24Hrs. 8. Date of I	Birth(MM	Forei	
Director		217-32-8	3199	1 XM 2	·	71	Yrs		riouis	11/1	2/19	935 C	ountry) MD
any		Usual Residence of 10a. State	Decedent 10b. County		10	oc. City, To	wn or Locat	ion					10d. Inside City Limits
* .	٦	MD	N	/A		В	ALTIM	IORE					1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Nu						10f. Zip Code			10g. Cit	tizen of What Co	untry?
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r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	Never Marrie	ed 2 X		Forces?	X No	If Y	es, specify Cuban	, Mexican,	Puerto Rican, etc.)		White, etc.	
after d al", or	by Fi	3 Widowed		vorced If Yes, Give	Year		1	Yes 2 X No			lach		VHITE
hours 'natur Exam	ted t	15. Decedent's Ed			grade comp e (1-4 or 5+			nt's Usual Occupat nost of working life.			166.	Kind of Business	s/industry
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5-0036 iled within 77 Hygiene d other than	Ö	17. Father's Name	,			a D				s Name (First, Middl			
2121 buld be fi Mental marked	To Be	ROBER'		SCHRIEB ship (Type, Print)		SR.	19b. Mailin	g Address (Stree		ERESA W ber or Rural Route I	ILS(Number,		ite, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	-	JOAN SCH		ER/ WIF	E					ENUE, BAL		ORE, MD	21224
ore, es 1 and of Heal If iten		20a. Method of Dis		on 3 Remov	al from State	e cre	ematory or o			Date		·	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 21. Signature of Fu				BAY		CREMATO				ALTIMO	
Bal permi Depar Impo injur				2	french de la constant			700 S. C	ZETI	LER INC. LING STR	FUI EET	NERAL I ,BALTO.	HOME , MD. 21224
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taminer	7	Immediate Cause or condition result	(Final diseas	se a. Atheros	clerotic C			sease					Death
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₩ . ₩ . ₩	Examine	(Disease or injury events resulting in	that initiated death) Las	Due to (or	as a consec	quence of):			_				
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Box 6876: c death certificate the attending phy ed for use as the l	cian/M	23b. Was deceden past 12 month	t pregnant in is?	'	ive birth regnant at t	ime of dea	.h - =	etal death 3 Other (Specify)	Ectopic	c pregnancy	- 1	Month	Day Year
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P.O. es that the igned by	by P	Part II. Other sign	nificant con	ditions contributi	ing to death	but not res	sulting in the	underlying cause	given in Pa			No 3 F	
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rision r Attend ter death. rrector: n by the f	ficat	2 Accident 3 Suicide	In	vestigation	Place of Inj	ury - At ho	me, farm, st	reet, factory, office	building, e		ion (Stree		r Rural Route Number, City
Divis 10 spital or A 24 hours after 5 funeral Dire	Certification:	4 Homicide	de	etermined (Spe	ecify)								
Division of Vital To the Haspital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,		29a. Certifier (Check only one)	Certifying Medical E	Physician: To the	e best of my	y knowledg nination an	e, death oco nd/or investig	curred at the time, gation, in my opinio	date and pl on, death o	lace, and due to the ccurred at the time,	cause(s) date and) and manner as I place, and due !	stated. to the cause(s)
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N		30. Name and ad			cause of d	eath (Item	23a)	11 Donn Stron	at Raltim	nore, MD 21201	 1		
	tate	Donna M. 31. Date filed (Mo			ant Medic			- Ferm Stree		1016, IVID 2 120	•		
Regis			OV 0 9	u.,	Pales.	A.	An	refer					
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		For State	State of M	arylan			Health and I	Mental Hy	/giene		
-		Registrar 1. Decedent's Name (First, Middle	le, Last)		- 06	ertificate of	Deam	2. Date of De	Reg. No.	2007	3. 3m En Deale 3
Physic /Med			Janice E	. Smi	ith			Month Novem	Day her 7	Year 2007	12:50AM M
Exami		4a. Facility Name (If not institution				4b. City, Town,	or Location of Death			County of Deat	
Andreas Maria Lang			Renita Lane				Bethesda				gomery
Funeral Director		5. Social Security Number 524–30–4090	6. Sex 7. A		last birthday Yrs.	Months Days		8. Date of Bi (Month, D	ay, Year)	Co	nplace (State or Foreign untry)
		Usual Residence of Decedent		79				April 2	8, 192	8 Co	olorado
filed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	_	10a. State 10b. County	,	10c. City	, Town or L	_ocation					10d. Inside City Limits
he Ma 8a-f s	Director		ntgomery				Bethesda				1 ☐ Yes 2 💢 No
with t		10e. Street and Number				10f. Zip Code	00017		10g. Citize	en of What Co	untry?
ms 23	Funeral	11. Marital Status	Renita Lane 12. Was Decedent	Ever in U.	S. 13	. Was Decedent of	20817 Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or N	0- 14	4. Race - Ame	
after or ite		1 ☐ Never Married 2 ☐ Mar	ried Armed Forces' 1 ☐ Yes 2 X			If Yes, specify Cul		o Rican, etc.)		Black, White	e, etc.
ural",	d by	3X Widowed 4 ☐ Divorced	Year or Dates:								White
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al Hyg	Be C	17. Father's Name (First, Middle,	, Last)				18. Mother's Nan	ne (First, Middle	e, Maiden S		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations					et and Number or Ru		_		
1 and Healt em 2		Richard W. Smith	i/ Son	20b. P	lace of Disr	oosition (Name of				Minnes ation - City or	sota 55347
ages ent of nt: If it		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		;		ematory or other plant Cemete		ember			
mit. F partm sortar / Injui		21. Signature of Funeral Service		14.	i i i i i i i i i i i i i i i i i i i	22. Name and Addr	ress of Facility RO	2007 bert A.	Pump	hrey Fu	Colorado ineral Home/
a E E E		1 den	Vestel	M0033	$35 \mid 1$	Bethesda- Bethesda,	Chevy Cha Maryland	se, Inc 20814-	3501	/ Wisco	onsin Avenue
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/Medical Examiner		, and an example of the second	Due to (or as		uence of):						
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death e atte	Physician/M	in the past 12 months? 1 □ Yes 2 🗖 No	1□Live birth 4□Pregnant a			□Ectopic pregnan □ Other (specify)	cy			Month	Day Year
that the de ned by the a	hys	9 ☐ Unknown	9□Unknown					1			
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± 0 € 1		25. Was case referred to medica	31				26 Plans of Dog			1 ☐ Yes	2 No
hysicia this cer al direct	o Be	examiner? 1 ☐ Yes 2 X) No	Hospital: 1 ☐ Inpat	ient 2	ER/Outpatie	ent 3 DOA	26. Place of Dea ther: 4 ☐ Nursing H	lome 5 X Res		□Other (Spe	cify)
Attending Physician: r death. ector: After this certific. by the funeral director,	Di: T	27. Manner of Death 1 X Natural 5 ☐ Pendir	28a. Date of Inj	ury ay Year)	28b. Time Injury			28d. Describe			
tendi eath. tor: A	catic	2 Accident investi	igation			M 1[Yes 2 No				
or At after d Direc in by	Certification:	4 Homicide determ	nined 28e. Place of In	ijury - At ho tc. <i>(Specif</i>)	ome, farm, s	street, factory, office	9	28f. Location City or To	(Street and own, State)	Number or Ru	ıral Route Number,
spital		29a. Certifier 1 Certifyl	ng Physician: To the bes	t of my kno	wledge, dea	ath occurred at the	time, date and place	e, and due to the	e cause(s) a	and manner as	stated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examina	tion and/or	investigation, in my	opinion, death occu	urred at the time	e, date and	place, and due	e to the cause(s)
To t	×	29b. Signature and title of certific	er				nse number			signed (Mont	
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17		30. Name and address of person Truong Bao, M					#210 P^	ckwilla	Max	vland '	20850
	ate	31. Date filed (Month, Day, Year,) 32 Regist	rar's Signa	iture		"210, RO	CKVIIIE	, rial	Jianu	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Summers 00 200 0000 esse /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Medical Center 15a Baltimor e Itimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 525-74-3348 Nov. 1936 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X☐ No Maryland Directo Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 977 Tidewater Road 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Pilot Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Summers Helen L. Irvin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mike Summers (son) 247 Dogwood Road, Upton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Logan Church of God Cem 2007 Logan, Illinois 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service License 3111 Mountain Road, Pasadena, MD 21122 sease, or completitions hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cau e on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart fa Immediate Cause (Final Myorardia Physician disease or condition resulting in death) /Medical Due to (o a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ner sician and burial-transit law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No Division or Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s 2□No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☑ Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA 0 this After this funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending to hours after death. (Month, Day Year) 5 Pending investigation 1 Natural n 24 hours and the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

15+1

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 9

DHMH 17 Rev 1/2001

10 N Greene St. Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08577 State of Maryland / Department of Health and Mental Hygiene Richard Matthew Sewell Certificate of Death 1- For State Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 4, 2007 0710 hrs Physician/ Sewell. Matthew Medic-' Examiner Richard 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore City** 1001 West Fayette Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min Country) 9 1969 Director Yrs 219-88-1736 1 XM 2 38 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 Yes 2 X No s 23a or 28a-f show a notified at once. Linthicum Maryland Anne Arundel 10g. Citizen of What Country? Director 10f, Zip Code 10e. Street and Number 21090 121 North Long Cross Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. 27 is marked other than "natural", or items in matic event, the Medical Examiner must be a Armed Forces? 1 Never Married 2 X No Yes Specify: White Yes 2 X No specify: Divorced If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ð 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Restaurant 21215-0036 Cook 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sewell Sr. Diann Beam Hiam Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20866 19a. Informant's Name/Relationship (Type, Print) ٩ 3918 Blackburn Lane Apt 13 Burtonsville MD ΩŽ Andrews mother Diann If item 27 i her trauma 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition lore. crematory or other place) Burial 2 Cremation 3 Removal from State 11/8/07 Baltimore MD Metro Crematory Inc. Other Speci Donation 5 Stallings Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licens 3<u>111 Mountain Road Pasadena</u> disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each Death 'edical Methadone intoxication and cocaine use Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED 27,28a-f, perME.g874. 12/4/07 TT physician the burial -23d. Date of delivery The law requires that the death certificate be 68760. 23c. If yes, outcome of pregnancy IF FEMALE Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Box 1 Yes 2 No 9 Unknown g Unknown ı signed by the a d be detached fo 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions O Yes 2 No 3 Probably 4 V Unknown ò σ. 24b. Were autopsy findings available Completed of Vital Records, 24a. Was an this certificate has been director, page 2 should prior to completion of cause of autopsy death? performed? No ✓ Yes 2 No 1 1 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ To the Hospital or Attending Physician: Be Nursing Home 5 Residence 6 Other: Scene Hospital: DOA ER/Outpatient 3 Inpatient 2 this 1 V Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day,Year) funeral After 27. Manner of Death Natural Yes 2 X No Division 5 Pending Fnd 11/4/2007 FNd 7:00 am within 24 hours after death. To the Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. ρ or Town, State) 6 X Could not be 3 Suicide 1001 W. Favette St. Baltimore, MD determined (Specify) found in house Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

29b. Signature and title of ceftifie

Jack Titus MD.

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Deputy Chief Medical Examiner

32. Registrar's Signature

المسالة متعالية

30. Name and address of person who completed cause of death (Item 23a)

2007

29d. Date signed (Month, Day, Year)

November 4, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 Edith Ellen Schwarz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ranklin Square Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 X F MD Jan. 4, Director 220-38-9808 65 1942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Counfy ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No MD N/A Be Completed by Funeral Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 4319 Parkwood Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and 2 should be filed within 72 hours after or lealth and Mental Hygiene. M 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify. Specify 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Day Care Day Care Provider 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Merryman George Shrader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9502 Goodspring Dr. Perry Hall, MD 21128 19a. Informant's Name/Relationship (Type. Print) 9502 Goodspring Dr. Karen Droter-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery
Cardens of Pain Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/9/07 Baltimore, MD 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. Baltimore, MD 21206 6415 Belair Rd r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List on, June 2015, and line. Approximate Interval Between Onset and Death 23a. Part I. Enter the diseas shock, or heart failure. Immediate Cause (Findisease or condition resulting in death) Physician neumoni9 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 12 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 KE200000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar varara

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

9000

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CLYDE TURNER HOVEMBER 5, 2001 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BURNIE ANNE SALTI MORE COARHINGTON MEDICAL HUMBEL PINTERS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/16/1923 9. Birthplace (State or Foreign Country) Kentucky 6 Sex 7. Age (In yrs. last birthday, Days Hours 1 MM 2 □ F 214 26 2021 84 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2000 Choptank 21122 U.S.A. Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Mayes 2 No 1939° If Yes, Give Year or Dates: 1945 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Price Turner Dora Jane Bentley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lott - daughter Test Road, York, PA 17404 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cem 11/8/07 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 21122 169 Riviera Dr. Pasadena, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIO MYO LATH SHEMIC Due to (or as a consequence of) OBSTRUCTIVE MAZONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Have and address of person who completed cause of cleath (Item 23a) (Type, Print) Gleu Burnie mi) drive 31. Date filed (Month) 32. Registrar's Signature State 2007 Registrar

filled in by

completely

within 24 hours at To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:35 R 100 /Medical 4a. Facility Name (If not institution, give street and nu Examiner Idlei BelAir 704 If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours untry) Yrs. Director 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a or Items 12. Was Decedent Ever in U.S. Armed Porces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 2 No Maryland 21215-0036 2 No 1 ☐ Yes If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) jd. MD21014 Baltimore, 20b. Place of Disp 20c. Location - City or Town, State 20a. Method of Disposition ition (Name of Department of H Important: If Ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐Removal from State alley Mem Gardens 9 4 Donation 5 Other (Specify) imenium 21. Signature of Funeral Service Lices 5+ H.11, MD 21050 1+ Cremention Services-Bellic or complications that caused the definition by one cruse on each line. 23a. Part1. Enter the diseas shock, or heart failure. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** one week /Medical Due to (or as a consequence of) Examiner prons. 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to for as a consequence of Division or Vital Records, P.O. Box 68760 the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1□ Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death Check onl one 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient this (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 37016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) De Hinon, cus Green Or Kenneth M. 6701 N. Charles

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Floren &

	State of Maryland / Dep	artment of Health and Mental Hy							
	1 - State Registrar	rtificate of Death	Reg. No 2007 36069						
Physician /Medical	1. Decedent's Name (First, Middle, Last) Dr. Umberto VillaSan	2. Date of Di Month Nov.	08, Day 2007 3. Time of Death 10:18 A M						
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
Funeral	4611 Cedar Garden Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday								
Director	214-44-7072 1™ 2□ F 80 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Month, D 0 6 - 1 7	ay, Year) -1927 Country) Italy						
a-f show ffied at	10a. State 10b. County 10c. City, Town or L MD Balti		10d. Inside City Limits 1 Z Yes 2 □ No						
3a or 28a-f sl st be notified al Director	10e. Street and Number 4611 Cedar Garden Road	10f. Zip Code 21229	10g. Citizen of What Country? U.S.						
al", or items 23e examiner must by Funeral	11. Mantal Status 1 Never Married 2 Married Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White							
Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation be kind of work done during most of working DO NOT use retired) ician/Gyn. Oncologis	16b. Kind of Business/Industry Professor Emeritus Univ. of MD Med. Ce						
Mental Hygie irked other t itlc event, th TO Be Co	17. Father's Name (First, Middle, Last) Mario Villa Santa	18. Mother's Name (First, Middle Carmen Bos	e, Maiden Surname)						
alth and I		ing Address (Street and Number or Rural Route Num 1 Cedar Garden Rd. Ba							
ment of He ant; If Item ury or oth		osition (Name of matory or other place) Date 11-09-07	20c. Location - City or Town, State Baltimore, MD						
Depart Import any inj once.	21. Signature of typeral Service License	22. Name and Address of Facility Joseph N. Zannino Jr. 263 S. Conkling St. E	Funeral Home Balto. MD. 21224						
/sician and leading le	23a. Part Tenter the disease, or som lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liv only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
d by the attending physic etached for use as the b	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	23d. Date of delivery Month Day Year							
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rector irector	25. Was case referred to medical examiner? NOT es 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient	26. Place of Death (Check only							
eral dir	27. Manner of Death 28a. Date of Injury 28b. Time	4 Nursing Home 5 Lives	sidence 6 Other (Specify)						
ral Director: After led in by the funer. Certification:	1 Matural 5 □ Pending investigation 3 □ Suicide 4 □ Homicide	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location	(Street and Number or Rural Route Number, own, State)						
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dead one of the companion of the passis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the nvestigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)						
To th comp	29b. Signature and tilla of contifier Afferdir Thysic	29c. License number 29d 3 6 5 1	29d. Date signed (Month, Day, Year)						
State	30. Name and address of person who completed cause of death (Item 23a) (Type Alam Reising 27 The Top Top Top Top Top Top Top Top Top Top	beipe Ral, Cotonsvill	85512 CM,						
Registrar	NOV 0 9 2007	certis							

	1	For State Registrar	State of Marylan		artment rtificate			nd Me	ntal H	ygiene Reg. No	2007	36070
		1. Decedent's Name (First, Middle, Last)						2.	Date of Month	Death Day	Year	3. Time of Death
Physici /Medic	al .		WILDE	12	45 Oit 7			Dooth	10	19	200 7 County of Dea	
Examin	er	4a. Facility Name (If not institution, give s		F	4b. City, T			Death			Baltim	
		Jewish Convalescen 5. Social Security Number 6. Sex		IOME last birthday)	If Under 1	svill Year I	Under 2	4 Hrs. 8	. Date of	Birth Day, Year)		rthplace (State or Foreign ountry)
Funeral Director		220-02-9399	M 24 85	Yrs.	Months	Days	Hours	Min.	OCT :	6 192	2	MD
p ,		Usual Residence of Decedent 10a. State 10b. County	10c Cit	v. Town or Lo	ncation							10d. Inside City Limits
shov	Funeral Director	MD Baltimor		wson								1 ☐ Yes 2 X No
the N 28a-f		10e, Street and Number	e 10	WBOII	10f. Zip (Code				10g. Citizen of What Country?		
3 with	ā	205 E. Joppa Road,	Apt. 402		2	1286					USA	
(1213	ner		12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decede	ent of Hisp	anic Orig Mexican,	in? (Speci Puerto Ri	ty Yes or can, etc.)	No-	 Race - Am Black, Wh 	erican Indian, ite, etc.
or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2	No .	Specity:				Specify:	hite
First (C)	ed by	3 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual	I Occupation	on			16b. Kir	nd of Busines	
n 72	plete	(Specify only highest grade	Completed) College (1-4or 5+)	(Give	kind of work DO NOT use	k done dur	ing most	of working	7			
21215-0036 sd within 72 hours att gional ar than 'natural', or tre Madical Exami	Completed	Elementary/Secondary (0-12)	2	Regi	stered						1thcar	'e
nd 2	ВеС	17. Father's Name (First, Middle, Last)				18		's Name (: r1 Be		dle, Maiden	Sumame)	
VIOLITICAL MENTS ANTRACT ANTRA	2	Karl Leberman				10.				mbas Citya	r Town, State	Zin Code)
Maryland and 2 should be file lith and Mental Hy 27 is markad oth r traumatic event		19a. Informant's Name/Relationship (Ty Dimitri Blondel —	pe, Print) grandson	6925	S.W.	46th	Avei	nue,	Gain	esvill	e, FL	32608
		20a, Method of Disposition	20b. F	lace of Dispo	osition (Nam	ne of	1	Da	te	20c. Lo	cation - City	or Town, State
nor lages ant of tt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	emetery, cre			no i	10/23	/200	7 Ra1	timore	· MD
Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or otha		21. Signature of Funeral Service Licens. Steven									nd, Inc	
Ball permi Depa Impo any ir		- HI	che-		299 I	rede	rick	Road	l, Ba	1timor	re, MD	21228 Approximate
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. September 1 September 2 Sep	quence of):								Interval Batween Onset and Death
Box 68760, — death certificate be executed e attending physician and d for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect									
P.O. Box 68 nat the death certifice d by the attending pletached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1								23d. Date of o	delivery Day Year
- 2 98	ρ	Part II. Other significant conditions co	contributing to death but not resulting in the underlying cau				ang occoor given an in an in			Oid tobacco		to the cause of death? Probably 4 ☐Unknown
of Vital Records, P.O Physician: The law requires that the rhis certificate has been signed by th rail director, page 2 should be detache	Completed									Mas an autopsy performed? es 2₽No	prior death	
Vital F iician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						of Death				
of Vita Physician: rthis certific ral director,	은	1 Yes 2 No		ER/Outpatie		-				Residence ribe how inju	6 □Other (S	pecify)
C S S	inol inol	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury		8c. Injury a Work? 1 □ Yi			00. 5030	100 11010 11110	,, 000000	
ivision arten ter deat irector:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8 28e Place of Injury - At home farm street factory office						8f. Locati City o	on (Street ai r Town, State	nd Number or e)	Rural Route Number,
To the Hospital c within 24 hours at To the Funeral D completely filled is	Medical Co	29a. Certifier Certifying Phy (Check only one)	vsicien: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea ation and/or	ath occurred investigation	at the time , in my opi	, date an nion, dea	id place, a ith occurre	nd due to	the cause(s ime, date an) and manne d place, and	as stated. due to the cause(s)
o the	Me	29b. Signature and title of certifier			290	c. License	number			29d. Da	ate signed (M	onth, Day, Year)
F S F Ö	1	Jami PH	45141			0006				15	20	2007
5		30. Name and address of person who co	No.	om 23a) (Type	e, Print) LE 2434	W-B	ELVE	- HGB Dere	REW AV	CIERI E BAI	ATRIC	CTR MD 21215
Si Regis	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sign		Carely 1	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 HAZEL WHETZLER NOVEMBER 2:47 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F 218-26-0813 **Director** 08-17-1915 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be nown or other traumatic event, the Medical Examiner must be nown. 109 Forest Valley Dr 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Assembly Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Goodrich Hazel Wilsoncroft 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Berry (Daughter) 242 Rachel Circle Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 11-08-2007 Baltimore, Maryland ^{22. Name and Address of Facility}Schimunek Funeral Home of Bel Air nc. 610 W. MacPhail Rd Bel Air, MD 21014 21. Signature of Funeral Service Licenses Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans P.O. Box 68760.9 The law requires that the death certificate be exec Due to (or as a consequence of) Physician/Medical ast IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has F autopsy performed 1□ Yes 2 | N 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the letely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

DAVID DUNN

Davel 5 D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W.

MACPHAIL ROAD
Registrar's Signature

ENGLI DO

the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

03227

BEL AIR, MD.

21014

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007 36072 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Clifford J. Weems, Sr. 2007 9:05 Α. Nov. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 **3** M 2 □ F 83 28, 1923 Maryland 215-14-9292 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits iled within 72 hours after death with the Maryland 10a State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at Yes 2 No Baltimore Director N/AMaryland 10g. Citizen of What Country? 10e. Street and Number USA 21239 6500 McClean Blvd #B1 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 √ Yes 2 □ No If Yes, Give WW 2 Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ₩ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) U.S. Post Office uth and Mental Hygiene. 27 Is marked other than "I r traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Mail Carrier 12th grade 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Hattie Chapman William Weems 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1213 N. Spring Street Baltimore, Md 21213 Clifford Weems, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Garrison Forest Vet. Cem. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Smeral Service Licens 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. .k., or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) DAYS **Physician** /Medical or as a consequence of): ACRAL WOUND Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-tran Box 68760, physician Physician/Medical the or use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No P.0. detached 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 2 has certificate 1∏ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Kther (Specify) Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) Injury Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the casse(s) and manner stated.

| death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co RLES ST. SUITE 209 BALLIMORE, MD 21204 \$2. Registrar's Signature Year) 31. Date filed (Month, Day, State 9 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 1140 AM Villie Ward November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Northwest Randall's tou Baltmore Under 1 Year | If Under 24 Hrs. onths Days Hours Min. 5. Social Security Number 6. Se Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🔀 F Director 85 242-26-0943 25 NC Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f sh notified a TX□Yes 2□No Director Windsor Mill MID NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or : ury or other traumatic event, the Medical Examiner must be r 21244 U.S.A. 7204 Bogley Road #201 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Liberty Medical Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Dietary na Center 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Davis Callie Covington ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type. Print) Husband John Ward-Baught 7204 Bogley Road #201, Windsor Mill, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 11/13/07 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21 Squature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. P. n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s. ock, or heart failure. List only one cause on each line. Immeriate Cause (Final Stroke Physician disea e or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year signed by the and be detached for 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown Hypertension Vein throm bosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 17 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066171 November MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edelman 5 401 61d 32. Registrar's Signature old Court Road Randallstown MD 31. Date filed (Month, Day, Year) NOV 0 9 2007 State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 9 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

NOVENBER 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:00AM 2007 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street Examiner Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Security Number **Funeral** 1 1 M 2 □ F Months Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐Yes 2 ☐ No NL) Funeral Director 14 more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No 1 🗆 Yes Specify: Saltimore, Maryland 21215-0036 WKI Be Completed by 3 Widowed 4 Divorced Year or Dates: Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Figral Route Number, City or Town, State, Zip Code) 21222 UTINNEMAN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Baltimore rematory: 11-10-07 4 ☐ Donation 5 ☐ Other (Specify) Brad Ky - Askton 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 2134 WILLOW SDING Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) My ocardial Infarction Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Injury 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D63382 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blud, Balfinone Duitay Pinelis Manyland 21239 . Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsu 16 Fusting Aup ommons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 15,1915 9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number 7. Age (In yrs. last bighday **Funeral** Months Days 1 □ M 2 F 91 217-07-6782 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 MYes 2 No ns 23a or 28a-f sh must be notified Director Baltimore N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21230 1824 Jackson Street Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 MWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 6 0 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be 01ga Fromnecht Charles J. Kane ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1824 Jackson Street, Baltimore, Maryland 21230 Catherine E. Muir (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 11-08-07 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensi McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. In rediate Cause (Final sease or condition resulting in death) Physician Havance /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Physician/Medical Examiner death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 Ne 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy page certificate 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 NO 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Accident 5 Pending injury Jospital c.
4 hours after dea.
---gral Director: After 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fo the ...
within 24 hours
-> the Funeral Dires.
-\text{\tin\text{\texi}\text{\text{\text{\texi}\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texit{\texi\texi{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{ 4 Homicide 29a. Certifier 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) Catonsville, MD 21228 30. Name and address

Registrar

State

31. Date filed (Month, Day)

Year)

2007

NOV 0 9

37, Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 36077 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 5, 2007 **Physician** 11:45 A M Florence Anne Zimmer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles La Plata Civista Hospital Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 75 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Days Min Months Hours 1 □ M 2 🕅 F 286-28-9966 Sept. 20,1932 Ohio Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature"—any injury or other transmission. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2X No La Plata MD Charles Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 United States 6670 Horseshoe Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 12. No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No Specify. Specify. 2 3XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unavailable) (Unavailable) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6670 Horseshoe Dr., La Plata, MD 20646 Michael R. Cutright / Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Uniformed Services 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/06/2007 Bethesda, MD 4 Donation 5 ☐ Other (Specify) University 22 Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Licensee m00382 Steplat Johnson 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPURTENSION /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1☐ Yes 2 No 1 Yes 2 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A

completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 172509 30. Name and address of serson who completed cause of death (Item 23a) (Type, Print) : 12070 OLD LINE CENTER #100 : WALDORF MD SMITH MA MEINHART 2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 9 2007 The series Registrar

Physician

/Medical

10a, State

Director

Completed by Funeral

Examiner

Funeral

Director

aftending physician and for use as the burial-transit ate has been signed by the page 2 should be detached

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Certificatio

Medical

State

Registrar

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Raman R. Tuli, M.D.,

3 Suicide

29a. Certifier

6 Could not be determined

dress of person who compl

NOVO

9

Division or Vital Records, P.O. Box 68760

Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	First, Middle, Maide	en Surname)	
2	Lawrence Zimmer			Rosa Seip	e1		
•	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailing Address (Stree	t and Number or Rural	Route Number, City	or Town, State, .	Zip Code)
	Rose-Marie Killeen	/ Sister	83 Rocky Point	Yaphank Rd	. #164, Roo	cky Poin	t. NY 11778
	20a. Method of Disposition	0.0	lace of Disposition (Name of emetery, crematory or other pla	Da Da		Location - City or	
	1 ☐ Burial 2 【XCremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	gomery Crematoriu	i	a	hesda, N	Maryland
	21. Signature of Funeral Service Licencee	_	Robert A. Fur				
	7.8.04	М0089	96 7557 Wisco	nsin Ave.,	Bethesda	MD 208	14-3501
	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	tions that caused the death cause on each line.	. Do not enter the mode of dy	ing, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
- 1	Immediate Cause (Final disease or condition resulting in death)	Urosepsis					1 month
	resulting in death)	Due to (or as a consequ	ence of):				
_	Sequentially list conditions, b. –	Urinary Blac					1 month
ine	if any, leading to immediate cause. Enter or denying Cause (Disease or injury	Due to (or as a consequent					
саш	that initiated events resulting in death) Last	Atherosclero					years
ω Ξ		Due to (or as a consequ	ience or):				
dice	d						
Ŋ.	IF FEMALE: 23c.	. If yes, outcome pf pregnar	ncv			00d D-4/ d-	
Siar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnance			23d. Date of de Month	Day Year
ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	Sum Signature (Specify)				
됩	Part II. Other significant conditions contrib	outing to death but not resul	Iting in the underlying cause given	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Completed by Physician/Medical Examiner	<u>Osteoarthritis</u>				1 ☐ Yes	2 No 3 Pi	robably 4 ⊠Unknown
olete	Dementia				24a. Was an	24b. Were at	utopsy findings available
шc			-		autopsy performed?	prior to death?	completion of cause of
Ö	25. Was case referred to medical			26. Place of Death (1☐ Yes 2█N	lo 1∐Yes	2 □ No
To Be	examiner?	pital: 1∏Inpatient 2∏E	ER/Outpatient 3 DOA Oth	ner: 4 Nursing Home		6 MOther /C	Assisted
	27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Inju	ry at 28	d. Describe how inj	ury occurred	CHY/LIVING
tion:	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day Year)		rk?]Yes 2⊟No			

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D19609

10810 Darnestown Road, Suite 202, Gaithersburg, MD 20878

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

November 6, 2007

DHMH 17 Rev 1/2001

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland? Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 08:30A M 2007 October 27, Frank Leo Binney Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11107 Shadybrook Ct. Lot 222 Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Yrs. Director December 24 1922 New York 084-16-3992 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Worle the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Washington Hagerstown 28a-1 Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ U.S.A. 21740 11107 Shadybrook Ct.Lot.222 "natural", or Items 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 XYes 2 □ No WYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 12 Painter of Health and Mentel Hygie litem 27 is marked other r other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mentel Important: If Itsm 27 is marked eny Injury or other traumatic evolute. Frank L. Binney Steele Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Metler / Daughter 2821 Jones Rd. Dunkirk Maryland 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/31/2007 Flintstone, Maryland MSVC-Rocky Gap 21. Sign Funeral Service Ricens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2√ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Chis 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

or Attending Physicien: The law requires that the death certificate be executed I Director: / filled in by within 24 hours after To the Funerel Dire Hospital

> State Registrar

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASS TH

11111

32 Registrar's Signature

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

35081

3. Time of Death

10:10 P M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Month

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 No

West Virginia

White

2007

4c. County of Death

2. Date of Death

November 1

Physician /Medical Examiner

Ashly May Bonar

4a. Facility Name (If not institution, give street and number)

Funeral Director

ns 23a or 28a-f shov must be notified at the death with 2 should be filed within 72 hours after and Mental Hygiene. ō "natural" other than "natu vent, the Medical 27 permit. Pages 1 Department of H Important: If Ite any Injury or ot once.

Baltimore, Maryland 21215-0036

NOVEMBER

SHLY BONAR

Physician /Medical

Examine

Examiner burial-transi the death certificate be executed Box 68760. the for signed by the a P.O. Division or Vital Records, or Attending Physician: funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

Stella Marris Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1 □ M 2 1 F Months Days Hours Min. Nov. 232-39-0747 16 1990 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Director Maryland Harkord Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 2202 Foley Road 21078 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 If Yes, Give 1 X Never Married 2 Married 1 Tyes 2 No. 2 Specify 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) Student Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Robin Bonar Tammy Lynn (Uhited) ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2202 Foley Road, Havre de Grace, Maryland 21078 Tammy Stoneberg (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris and Co. 11/5/2007 Wester Chester. PA 4 ☐ Donation 'S ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Welman Mitchell Smith Funeral Home 123 S. Washington St. Havre de Grace, MD 21078 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Due to (or as a consequence of) Traumatic Brain Injury with Complications Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Kres SIM No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 6:30^p• M 5 ☐ Pending investigation 1 Winatural 1 ☐ Yes 2 ☑ No Accident 3 Suicide 02/15/2007 Sledding Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Yard Conowingo, MD 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital

2300 DULANEY VALLEY RD.

3# Registrar's Signature

29c. License number

TIMONIUM, MD 21093

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S Regis	tate trai
DHMH 17 Rev 1/2 OCME 2006	2001

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ald Wade Br		ey, Jr. Stat 1- For State	e of Maryland /	-	rtment of F tificate of D		ntal Hy	giene		200	7 2000
Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast)	Cer	uncate of L			Reg. 2. Date of Death	No.	201	3. Time of Death
Filysicia dical Exami	41.07	Ronald Wade BR						Month Do		ear	2119 hrs
		4a. Facility Name (if not institution,	give street and number)		4b.	City, Town, or Location	of Death		4c. Count	y of Death	
		Washington County Hos	pital			Hagerstown			Washi		
Funeral				(In yrs. la	ast birthday)	If Under 1 Year If Und Months Days Hour	der 24Hrs.	.8. Date of Birth(I	MM/DD/YY	Foreign	
Director			X M 2 F	39	Yrs.			Dec. 27	, 196	7 Cou	ntry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location						10d. Inside City Limits
* *		Maryland Washin	gton	Ha	gerstown	1					1 Yes 2 X No
larylar 8a-f s at on	ector	10e. Street and Number	80011	IIa		10f. Zip Code		10g.	Citizen of	What Coun	ry?
ith the Maryland 23a or 28a-f show notified at once.	Ö	16349 Mt. Tabo	r Road			21740			USA		
h with	uneral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.		Decedent of Hispanic On , specify Cuban, Mexica			14. Ra	ice - Americ	an Indian, Black,
r deatl or ite must	Fun	1 Never Married 2 Marri	1 Yes 2	X No				dodny otory			
136 thin 72 hours after than "natural", edical Examiner	þ	3 Widowed 4 X Divorce 15. Decedent's Education (Specify	ced If Yes, Give Year or Dates:	nleted)		es 2 X No specification (Give		ork done 1	Specif	y: Wh Business/In	nite
2 hou "nat	eted	Elementary/Secondary (0-12)	College (1-4 or 5			t of working life. DO NO					l
036 ithin 7 ne. r than	ompleted	12	0		Roof	er			Roo	fing	Company
5-0036 ifed within 7 Hygiene. I other than	ပ	17. Father's Name (First, Middle, La	ast)			18.Moth	er's Name (First, Middle, Ma	den Surnar	me)	
21215-0036 wild be filed within 72 hours after Mental Hygiene marked other than "natural", of event, the Medical Examiner.	o Be	Ronald Wade Br 19a. Informant's Name/Relationship	adley, Sr.		10h Mailing A	Man Address (Street and Nu	ry R.	Mowbray	r City or T	ours State	Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ĭ	Leslie Groves									W. Va.25419
and 2 tealth item 2 traur		20a. Method of Disposition			Place of Disposition	on (Name of cemetery,	DITVE				Fown, State
ages lant of the rite of ther		1 Burial 2 X Cremation		re.	crematory or othe		10/3	30/07	Напо	retou	n, Maryland
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Spec 21. Signature of Funeral Service Lin	cify: censee	IIa		me and Address of Facil		innich F			
Dep Der Injury		(Polita Dian	l-i		41	5 E. Wilson					
Physician		23a. Part I. Enter the disease, or co failure. List only one cause or		the death	. Do not enter the	mode of dying, such as	s cardiac or	respiratory arres	, shock, or	heart	Approximate Interval Between Onset and
/Medical .caminer		Immediate Cause (Final disease	a. Electrocution								Death
		or condition resulting in death)	Due to (or as a conse	quence o	f):						
	Эeг	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence o	f):						
	Examiner	(Disease or injury that initiated	c. Due to (or as a conse	quence o	ıf)·						
xecuted n and I - transit		events resulting in death) Last	d.	4001100							
5 5 E	ian/Medical	UNPENDED	AMENDED								
Records, P.O. Box 68760, The law requires that the death certificate be exteat has been signed by the attending physician page 2 should be detached for use as the burial.	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of preg	inancy					e of delivery	
certification of the same of t	ician	past 12 months?	1 Live birth 4 Pregnant at	time of de		I death 3Ector er (Specify)	pic pregnar	ncy	Monti	h [Day Year
Box e death c the atten ed for us	S	1 Yes 2 No 9 Unkno	h-m-man		J Othe	er (Specify)					
P.O.	y Phy	Part II. Other significant conditio	ns contributing to death	but not r	esulting in the un	derlying cause given in	Part I.				the cause of death?
ords, P.C. w requires that is been signed t should be deta	ed by	Hypertensive atherosc	lerotic cardiovascu	lar dise	ase						ably 4 Unknown
cords law requi has been 2 should	plet							24a. Was ar autopsy	,	prior to d	topsy findings available completion of cause of
Records, The law requir ficate has been s, page 2 should t	Completed							perform 1 Y Yes 2		death? 1 ✔ Ye	es 2 No
tal Rection: The certificate ector, page	Be (25. Was case referred to medical examiner?	Hospital:	posen		26.Place of Dea		pro-tra			
ision of Vital I Attending Physician: r death. ector: After this certifi by the funeral director,	2	1 Yes 2 No 27. Manner of Death	28a Date of Inju	D/	ER/Outpatient 28b. Time of Inj	0		28d. Describe ho	esidence w injury oc		7.
n of rding Pl th.: After e funera	ion:	1 Natural 5 Pendin	FOUND: Day,Y	ear)	FOUND:	1 Yes 2					king on dryer
	icat	2 ✓ Accident Investi	gation Oct 27, 2007	jury - At h	2125 hrs ome, farm, street	, factory, office building,	, etc.	28f. Location (St	eet and Nu	ımber or Ru	ral Route Number, City
Divi Hospital or 24 hours after Funcral Directly filled in 1	Certification	3 Suicide 6 Could 4 Homicide determ		gle Far	mily			or Town, Sta 16349 Mount T	ite) abo Road	, Hagersto	own, MD
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Phy	sician: To the best of miner:On the basis of exa								
To To	Med	29b. Signature and title of certifier	and manner stated.			29c. License numb	er		29d. Date s	signed (Mo	nth, Day, Year)
		Aflina Bra.	nell Mo			O.C.M.E.			October	28, 200	7
H-1		30. Name and address of person w Melissa Brassell, MD	Assistant Medical	Exami	ner 111 Pe	enn Street, Baltimo	ore, MD	21201			
S Regis	tate trar	31. Date filed (Month, Pay Year)	2007 32. Registra	r's Signat	ure	do					
HMH 17 Rev 1/2		OCME	A CONTRACTOR OF THE PARTY OF TH	A STATE OF THE PARTY OF THE PAR	ORIGINAL						

			For State Registrar	State of Mar		Certificate of		vientai Hy	giene Reg. No	2007	36083
4	Physicia		1. Decedent's Name (First, Middle, Las	ann Brady	,			2. Date of De Month Octobe	Day	Year 2007	3. Time of Death 10:40 P ^M
í.	/Medic Examin	- 1	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat			County of Death	
<i>K</i> -	- LAGIIII	Ÿ.	Anne Arundel Med	ical Center		Anna			A	nne Aru	
	Funeral Director		5. Social Security Number 6. S 212-42-5089	ex 7. Age (☐M 2ÅF	(In yrs. last birt	hday) If Under 1 Year Months Days	Hours Min.	8. Date of Birl (Month, Da March 18	y, Year)		place (State or Foreign intry) yland
	land w		Usual Residence of Decedent 10a. State 10b. County		I0c. City, Town	or Location					10d. Inside City Limits
	Mary -f sho fied a	tor	Maryland Queen	Anne's	Queer	n Anne					1 □Yes 2√ No
	or 28a	Director	10e. Street and Number	uuu s		10f. Zip Code			10g. Citiz	en of What Cou	entry?
	23a c		118 Sycamore Lane		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	21657			Unite	d State	es of America
	ltems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	. 1	 Race - Amer Black, White 	
36	irs aft Il', or xami	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏ Yes 2 DaNo If Yes, Give Year or Dates:		1 ☐ Yes 21☐ No	Specify:			Specify:	icasian
2-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Ec	lucation	16a.	Decedent's Usual Occup	nation	rking	16b. Kin	d of Business/li	
7	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work done life. DO NOT use retired		ining	4.1.6	u a	
22	filed w Hygier Ither th		17. Father's Name (First, Middle, Last)			Health A		me (First, Middle,		L Day (Gurname)	are
Maryland 2	be od o	To Be	,	Hastings S	terlin	g	Mari	, Estel	le P	addy	
ary	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (ter 19b.	Mailing Address (Street					' '
	s 1 and 2 if Health item 27 i		Deborah Thompson	Callahan		09 Quail Lar					
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			Disposition (Name of y, crematory or other plan	,	Date		ation - City or T	
altimore,			4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Cities		Green	nount Cemete					
Ba	permit. Departr Importa any Inj		+ auctiful	Mare		22. Name and Addre Moone Fund 12 South	ral Home	P.A. D	ent on	· Manuel	and 21629
В	-		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	ne death. Do r	not enter the mode of dyin	ng, such as cardia			, narga	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	L	ung can	cer				Onset and Death
01	/Medical Examiner		resulting in death)	Due to (or as a	consequence o	of):					
	LXammer	ž	Sequentially list conditions, if any, leading to immediate games. Each of Underhaling	b. Due to (or as a	consequence of	of):					
	unsit	Examiner	Cause (Disease or injury	200 10 (01 40 4	oonooquonoo						
o,	execu an and rial-tra		that initiated events resulting in death) Last	Due to (or as a	consequence o	of):					
68760	ificate be executed g physician and as the burial-transit	edical		d							
	= D m	/Mec	IF FEMALE:	23c. If yes, outcome p	f pregnancy					Od Data of dall	
Box	death certifi e attending d for use as	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		2	3d. Date of deli Month	Day Year
Ö.	ires that the de signed by the a be detached f	Physician/M	1 ☐ Yes 2 🖔 No 9 ☐ Unknown	9□Unknown							
S,	The law requires that the te has been signed by the hage 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause giv	en in Part I.				the cause of death?
ord	w requir been si should I							18	Yes 2	No 3∏Pro	obably 4 ∏Unknown
Sec	The law cate has b page 2 st	Completed						24a. Was auto		24b. Were au prior to d death?	topsy findings available completion of cause of
Vital Records,			25. Was case referred to medical				00 Di f D .	1□ Yes	26 No	1 ☐ Yes	2 No
	yslcian: is certific director,	To Be	examiner? 1 \(\text{Yes} 2 \) No	Hospital: 1 X Inpatien	t 2 □ ER/Ou	tpatient 3 DOA Oth	or.	ath <i>(Check only c</i> Home 5 ☐ Resi		☐Other (Spec	cify)
סכ	ding Phy h. After this funeral c		27. Manner of Death	28a. Date of Injury (Month, Day	28b. 1	Firme of 28c. Inju		28d. Describe			,
SIO	endir eath. or: Af the fur	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1□	Yes 2□No				
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur building, etc.	y - At home, fa (Specify)	rm, street, factory, office		28f. Location (City or To	Street and wn, State)	d Number or Ru	ıral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 ☑ Certifying Pt	ysician: To the best of	my knowledge	e, death occurred at the ti	me, date and place	e, and due to the	cause(s)	and manner as	stated.
	n 24 h	edicat	(Check only 2 Medical Examone)	niner: On the basis of e and manner state		d/or investigation, in my	opinion, death occ	urred at the time	, date and	place, and due	to the cause(s)
	Vithi Vithi Com	Ž	29b. Signature and title of certifier	111201	1 = 3	29c. Licens	se number		29d. Date	e signed (Monti	h, Day, Year)
)			1 7, qui	my u		Ul	4838		101	311 20	OT
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, Print)	Besto	ale Ro	1. A	миаро	007 lis Md. 2140
9	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature						
	Registi	ar	NOV 1 20	07	, B	forthe					
DH	MH 17 Rev 1/2	001	1 50	The same of the sa	9"						

AS 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 2,2007 **Physician** 11:50AM B. BROWN VICTORIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE CAROL CARE NURSING HOME SPRING DALE MARYLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months Days Hours Min. | 7 U L Y 2 3 19 13 V I R C V N I A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕅 F 218-22-3802 94 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County fshow a or 28a-f show be notified at PRINCE GEORGE UPPER MARLBORO 1 X Yes 2 □ No MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9608 CEDAR HOLLOW LANE 20774 U.S.A. "natural", or Items 23a within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: BLACK þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE NURSE permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALICE RICH BROOKS ROBERT BROOKS ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9608 CEDAR HOLLOW LANE UPPER MARLBORO MARYLAND 20774 *CHARLES WEAVER(NEPHEW)* 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BEULAH BAPTIST CHURCH 10/6/07 LIVELY VIRGINIA ■Qonation 5 ☐ Other (Specify) ign ure of Funeral Service License 22. Name and Address of Facility BERRY O. WADDY 0 6784 MARY BALL ROAD P.O. BOX 305 LANCASTER VA. 22503 Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician a. CON ESTIVE HEART FAILURE /Medical Dusto (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) certificate be executed RENAL INSUFFICIENCY Exami that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached it Ö 9 I Inknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မှ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 1 🛚 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending s after dea.

al Director: After To the Hospital or within 24 hours af To the Funeral D

> State Registrar

Medical

31. Date filed (Month, Day, Year)

NDU ACHUFUSI, M. D.

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

7940 JOHNSON Registrar's Signature

NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AVENUE GLENARDEN MD. 20706

D 46591

29d. Date signed (Month, Day, Year)

			1- State of Mary	-	artment of He rtificate of E		_		07 36085
	Physici		Decedent's Name (First, Middle, Last) Roy Edward Campbell	. Sr.			2. Date of De Month	Day er 22, 20	3. Time of Death 007 9:35 P ^M
	/Medio Examir Funeral		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	4b. City, Town, or Silver S If Under 1 Year Months Days			4c. County	
L	Director		231-14-1743	86 Yrs.	Workins Days	riouis Willi.		1, 1920	Virginia
	yland low at		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar 3a-f sh tified	Director	DC N/A	Wash	ington				1 😿 Yes 2 🗆 No
	a or 2		10e. Street and Number		10f. Zip Code			10g. Citizen of W	
	ms 23	Funeral	1342 Taylor St., N.W. 11. Marital Status 12. Was Decedent Ever	in U.S. 13.	20011 Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No	U • 1	- American Indian,
036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	þ	1 ☐ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 194		1 ☐ Yes 2 ☑ No		o Hican, etc.)		k, White, etc. Black
215-0036	be filed within 72 hours after death with the Marylan tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	ation Juring most of word	king	16b. Kind of Bu	siness/Industry
7 7	filed within Hygiene. other than " ent, the Med	Com	12	Pri	nter Reco				al Government
yiand		Be	17. Father's Name (First, Middle, Last)					, Maiden Surnam	
	ges 1 and 2 should be it of Health and Menta If item 27 is marked or other traumatic ev	ဥ	Harry Roscoe Campbell 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a			a Brooks	
Mar	and 2 s ealth ar n 27 is er trau		Elizabeth B. Campbell / Wife		Taylor St				
o. e	ges 1 a t of He If item or othe		20a. Method of Disposition 2 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	0b. Place of Dispo		i	Date		City or Town, State
gaitimore,	t. Pages tment of I tant: If ite		4 □ Donation 5 □ Other (Specify) □	incoln M	em. Cem.	Oct.	31, 20	07 Sui	tland, MD
g	permit. Pag Department Important: Is any Injury o once.		21. Signature of Europeal Service Licensee						ervice, Inc.
Ģ.	- 6		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	spirator	y Failure				Onset and Death 1 hour
	/Medical Examiner		Due to (or as a col	nsequence of):					
x		er	Sequentially list conditions, if any, leading to him conditions cause. Enter Underlying Cause, (Disease or injury) Acute My		filtrates				1 week
)	cuted Id ransit	Examiner	that initiated events	elogenou:	s Leukemia	a.			3 months
Ď,	oe execian ar	EX	resulting in death) Last Due to (or as a con	nsequence of):					
68/60,	ificate be executed g physician and as the burial-transit	edical	d						
O. Box	ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf propriate in the past 12 months? 1 □ Live birth 2 □ Unknown 1 □ Live birth 2 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Dat Mor	e of delivery nth Day Year
Ά, J	s that in ned by a detail	by Ph	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use contr	ribute to the cause of death?
Suga	w requires that the deben signed by the should be detached		Acute Renal Failure				1 🗆	Yes 2□ No	3 ☐ Probably 4 ☑Unknown
ecord	2 SS 2	Completed	Neutropenia with Fever				24a. Was	psy p	Were autopsy findings available prior to completion of cause of
Vital K	Th ate pag	Con					perfe 1∐ Yes		death? ☐Yes 2☐No
	Physician: The this certificate all director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1X Inpatient	2 ☐ ER/Outpatier	ot 3 DOA Othe	26. Place of Dea			
0			27. Manner of Death 28a. Date of Injury	28b. Time o	" 3 DOX	4 LI Nursing H		idence 6 Other	
SIO		atio	2 Accident investigation		M 1□Y	res 2 □ No			
DIVISION	tal or Atten s after deatl al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury building, etc. ⟨S⟩	At home, farm, str pecify)	reet, factory, office			(Street and Numb wn, State)	er or Rural Route Number,
	To the Hospital or A within 24 hours after on To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, deat mination and/or in	th occurred at the time expressigation, in my or	ne, date and place pinion, death occu	e, and due to the irred at the time	cause(s) and ma , date and place,	nner as stated. and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		29c. License	number		29d. Date signed	d (Month, Day, Year)
)	1401		'			52503		October	23, 2007
0	,		30. Name and address of person who completed cause of death Dr. Shiailesh Sheth 1500 Fo		nn Rd. Si	lver Snr	ing. MD	20910	
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's S	Signature	ne ku . DI.	bpr			
	Registr		101.1 7 Is /101/ #8/4	And Aller					

DHMH 17 Rev 1/2001

07-08527	
Jeremiah Cruz	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Registrar	Death	Reg	. No.	1 3508
Physicia edical Exami		Decedent's Name (First, Middle,Last)		2. Date of Death Month November 2		3. Time of Death 1312 hrs
euicai Exaiiii	IIEI	Jeremian Crispino Ciuz, Ji.	b. City, Town, or Location of Deat		4c. County of Death	13121113
)		Shady Grove Hospital	Rockville		Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		_	(MM/DD/YYYY) 9. Birth Foreign	
Director		216-79-5701 1XM 2F Yrs.	Months Days Hours Mir	07/22/		ntry) DC
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
<u>*</u> .						1 Yes 2 X No
vlaryland 28a-f show 1 at once.	Director	Maryland Montgomery Germant 10e. Street and Number	OWN 10f. Zip Code	100	g. Citizen of What Coun	ry?
th the M 23a or 2 notified		12548 Cross Ridge Way	20874		United St	ates
h with thems 23a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (Sees, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	
er deat	Fun	1 Yes 2 X No		o radan, oto.)		
urs afte	J by	or Dates:	Yes 2 X No specify: t's Usual Occupation (Give kind of	work done	Specify: As i	313-2-1
72 hor "na" na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during mo	ost of working life. DO NOT use re	tired)		
003(within iene.	mc	0	None		N/A_	
MD 21215-0036 4.2 should be filed within 72 hours after death with the Maryland that and Montal Hygiene a 77 is marked other than "natural", or items 23a or 28a-f she unnatic event, the Medical Examiner must be notified at once	Be C		18.Mother's Nam	ne (First, Middle, Ma	•	
212 212 2uld be Ment mark	о В	Jeremiah S. Cruz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or	Rural Route Numb	e Crispino er, City or Town, State,	Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Healand and Menda Hygiene I ant! I friem 27 is marked other than or other traumatic event, the Medical	Ċ	Michelle Crispino/Mother 12548	Cross Ridge Way	, German	town, MD. 2	.0874
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or oth	ition (Name of cemetery, ner place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If itel		4 Donation 5 Other Specify: St. Rose of	of Lima Cem. 11/	06/2007	Gaithersbu	ırg, Md.
Balt permit Depart Impor	-		lame and Address of Facility De			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	East Deer Park I ne mode of dying, such as cardiac	Or., Gait or respiratory arres	hersburg, st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden infant death syndr	rome			Between Onset and Death
aminer		or condition resulting in death) Due to (or as a consequence of):	<u> </u>			
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
n	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
recuted and		events resulting in death) Last Due to (or as a consequence of): d.				
ial ar	Medical	X UNPENDED X AMENDED #1,23a,27, perME, g876, 2/	11/08 TT			
760, ficate be g physicia the buria		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	- V
30x 687 death certific e attending p	iciar	past 12 months? 4 Pregnant at time of death 5 Out	tal death 3lEctopic pregr ner (Specify)	laricy	Month D	ay Year
Box ne death or the atten	Physician	1 Yes 2 No 9 Unknown 9 Unknown		Tan Billion		
P.O. Besthat the degreed by the	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to t	
	Completed		· · · · · · · · · · · · · · · · · · ·	24a. Was ai	n 24b. Were au	opsy findings available
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tal Rec cian: The l certificate !	ပိ	25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Ye	s 2 No
de E	To B	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient	3 DOA Other Nurs	ing Home 5 F	Residence 6 Other	
		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Ir		28d. Describe ho	ow injury occurred	
Division tal or Attendi rs after death. al Director: /	catio	2 Accident Investigation 28e. Place of Injury - At home, farm, stree	1 Yes 2 No	29f Location (St	reet and Number or Ru	nl Poute Number City
Division or At ours after derail Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)	t, ractory, office building, etc.	or Town, Sta		ar Noute Number, City
Hos 24 h Fini		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr				
To the Hos within 24 h To the Fin completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		at the time, date a		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E. OCM	ME	November 3, 200	
		30. Name and address of person who completed dayse of death (Item 23a)	J.C.IVI.E.	T76a	3, 200	
			111 Penn Street, Baltimo	re, MD 21201		
	ate	PART V 11 25 / 1111 / 1000 174 1740	Es.			
Regist	ırar	HOT OF COOL PROPERTY OF PERSON	4 35			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Bennie Azalea Crutchfield 23, 2007 Oct. 8:42 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Oct. 17, 1902 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 X F Yrs 105 Virginia 577-40-8764 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 'naturai", or items 23a or 28a-f show di-al Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 7051 Carroll Avenue #412 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. by 3 ☐ Widowed 4 ☑ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 | (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American University 9th Housekeeper other permit. Pages 1 and 2 should be file Department of Health and Mental Hy important; if Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Crutchfield Mary Broadus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) G. Janice Quarles/Niece 4415 7th St NW Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-26-2007 | Washington, DC Rock Creek Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, NW Washington, DC 23a. Part Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Hypovolemic Shock /Medical Due to (or as a consequence of) Examiner Gastrointestinal Bleeding Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of Examine and Due to (or as a consequence of) burial-1 physician Physician/Medical the SS attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate I 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 🔲 Inpatient 2 X ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

certificate be executed Division or Vital Records, P.O. Box 68760 The

the Maryland

with 1

death \

nours after

Baltimore, Maryland 21215-0036

Hospital or Attending 24 hours after death Funeral Director: the the 0

Medical

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier (Check only one)

1517 Hugo Circle Silver Spring, MD Alan R. Segal 32. Registrar's Signature 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D52261

20906

29d. Date signed (Month, Day, Year)

October 24, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 1, 2007 Medical Examiner 1334 hrs Lee Dodd 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 37 North Conococheague Street Williamsport Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Director 212-98-3374 Country Maryland 1 XM 2 Dec. 24, 1974 Yrs Usual Residence of Decedent any Ob. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 X Yes 2 No MD Washington Williamsport event, the Medical Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mental Hygiene. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 37 N. Conococheague St 21795 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 X No Yes Widowed Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: White ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Food Service Manager 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be <u>Terry Lee</u> Dodd Debra Vanette Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra V. Hann/Mother 20325 Youngstoun Ct., Apt.2705 Hagerstown, MD 21741 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place Burial 2 X Cremation 3 Removal from State 11/2/2007 Alexandria, VA Metropolitan Crematory Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part I. Enter the disease, or complication failure. List only one cause on each ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interva Between Onset and 'Medical Death Ruptured Aortic Dissection aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Exar Due to (or as a consequence of): events resulting in death) Last and rransit Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 ✔ Unknown Completed funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy pnor to completion of cause of performed? death? ✔ Yes 2 No 2 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 ✓ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending Yes 2 No filled in by the To the Funeral Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 2, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

32. Régistrar's Signature

State Registrar

Physicia /Medic		1. Decedent's Name (First, Middle, Last)		tificate of D		2. Date of De	Reg. No	~2007	3. Time of Death
		Allan Perry Dickenso	n			Month Oct.	31		10:40 PM
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Death		40	c. County of Death	10.40
	200	16833 Melville Road		Henders	son				line
Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. l.</i> 157–22–8048 11 № 2□F 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	av, Year	r) Coui	
Director		Usual Residence of Decedent	115.			Aug 1	0 1	929 Vir	ginia
show ed at	J.	10a. State 10b. County 10c. City	, Town or Lo					1	0d. Inside City Limit
28a-f lotifi	Director	Maryland Caroline Hen 10e. Street and Number	derso	10f. Zip Code			10a C	itizen of What Cour	atru?
a or		16833 Melville Road		21640)			J.S.A.	,
ns 23 mus	Funeral	11 Marital Status 12. Was Decedent Ever in U.	S. 13. V	Was Decedent of His f Yes, specify Cubar		pecify Yes or No		14. Race - Americ	an Indian,
ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cubar I □ Yes 2X No		o Rićan, etc.)		Black, White, Specify: Wh	etc. ite
ene. than "naturai", or items 23a or 28a-f show he Medical Exa <u>miner must be notified at</u>	Completed I	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done do DO NOT use retired)	tion uring most of wor	king	16b. I	Kind of Business/In	dustry
than than he Me	m d	Elementary/Secondary (0-12) College (1-4or 5+)		e manaq			Ca	ico publ	ic works
Hygi ther nt, t		17. Father's Name (First, Middle, Last)	wasc		18. Mother's Nam	ne (First, Middle	_		10021-1
Mental larked o	To Be	John K. Dickenson			Janie	Griffi	n	Dicken	son
f Health and Men tem 27 is marke other traumatic	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street a	nd Number or Ru	ral Route Numb	ber, City	or Town, State, Zip	Code)
27 is r trau		Joyce G. Dickenson/ wife	168	33 Melv:	ille Ro	ad: He	ende	erson. M	D 21640
f Health item 27 i other tra		20a. Method of Disposition 20b. P	lace of Dispo	sition (Name of natory or other place		Date		ocation - City or To	
ento ny or				ake Cre		11/1/0	17	Chester	, Maryla
Department of I important: If ite any Injury or of once.		21. Signature of Funeral Service Licensee	\mathbf{F}^{22}	Name and Address Leegle at	nd Helf	enbeir	ı Fu	neral H	lome, PA
		22a Part Enter the disease or complications that caused the death	PC	Box 161); Gree	nsboro	N N	1D 21639	Approximate
		23a. Part1. Enter the disease, or complications that caused the deals shock, or heart failure. List only one cause on each line.					arrest,		Interval Between Onset and Death
nysician Medical		Immediate Cause (Final disease or condition resulting in death) a. Metastat		rostate	Cancel				2004
kaminer		Due to (or as a consequ	uence of):						
· 44	<u>-</u>	Sequentially list conditions, Due to jor as a consequ	ence of:						
nsit	Examiner	Sequentially list conditions, if any list of the cause. Enter Underlying Cause (Disease or injury that initiated events c.							
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ned by the a detached f	hys	9 ☐ Unknown							
ned l		Part II. Other significant conditions contributing to death but not resu	_	nderlying cause give	n in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
n sign	d be	Emphesema, (B) sided heart fa	ilure			1 🗆	Yes :	2 <mark>⊋N</mark> o 3□ Prol	bably 4 □Unknov
s been si	Completed by	. , -				24a. Was	s an	24b. Were auto	opsy findings availab
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certificate rector, pag	a	25. Was case referred to medical			26. Place of Dea	1 Yes		io Times	2 140
direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien	Totha	**			6 □Other (Speci	fv)
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within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knot Medical Examiner: On the basis of examinating and manner stated.							
E # 6	Me	29b. Signature/and tiple of certifier		29c. License	number		29d. D	ate signed (Month,	Day, Year)
100		x Hand V. III	1	Unn	70873				
within 24 To the F complete						I			
To COIT		30. Name and address of person who completed cause of death (Item	23a) (Type,	Drint)	0175		1 100	cober "	,2007 D 21634

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of N	Marylan		artment of F rtificate of			Reg. No.	36091
*	Physicia /Medic		1. Decedent's Name (First, Middle Joanne Catheri	ŕ					2. Date of Dea) Cr ^{Day} 3 2°°°	3. Time of Death 0927A M
	Examin		4a. Facility Name (If not institution Washington Cou	_			4b. City, Town, o Hage.	r Location of D rstown		4c. County of De Washi	
	Funeral Director		5. Social Security Number 212-66-7705	6. Sex 1 □ M 2 ☑ F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth Ain. (Month, Day April 9	9. B (, 1954 Ne	irthplace (State or Foreign Country) W York
	yland iow at		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo					10d. Inside City Limits
	the Mar 28a-f sh	Director	Md. Was	hington			Hagersto	wn		10g. Citizen of What (1 ☐ Yes 2 💆 No
	th with 1 23a or 3 ust be n		10021 Melody La	ne				1740		U.S.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 ▼ Privorced	12. Was Decede Armed Force ed 1 Yes 2 If Yes, Give Year or Date:	s? ∑∏No		Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2 ☑ No	lispanic Origin' an, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
21215-0036	vithin 72 ho ne. han "natur e Medical I	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education of grade completed) College (1-4c)	or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Busines Health	
2	e filed v al Hygie I other t vent, th	Be Co	9 17. Father's Name (<i>First, Middle,</i>	Last)			Nurse		Name (First, Middle,	Maiden Surname)	
Maryland	hould b id Ment marked matic e	70	Fred W. Simm 19a. Informant's Name/Relationsl			19b. Mailir	ng Address (Street		line J. Mc	Ne11 er, City or Town, State	Zin Code)
, Ma	and 2 sealth ar m 27 is		Donna M. Bartos		1	24 E	. Antieta		Hagerstown	,Md. 21740)
more	Pages 1 ent of H nt: If ite ry or otl		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S _i		. 0	emetery, crei	sition (Name of matory or other pla rg Cremat	Orn i	Date DV. 6,	20c. Location - City of Smithsbur	•
Baltimore,	permit. I Departm Importar any Inju		21. Signature of Funeral Service		Mo 14	7/4 J	2. Name and Addre			525 Bradbuithsburg,	
	#		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death	h. Do not ent	er the mode of dyin	ng, such as car	rdiac or respiratory ar	rest,	Approximate interval Between Onset and Death
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	Examiner	eľ	Sequentially list conditions,	b. Due to (or	as a conseqi	uence of):					
η.	executed and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequ	uence of):					
68760,	cate be e	edical E		d							
O. Box 6	The law requires that the death certificate be executed to has reen signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	n 2 □ Feta t at time of d	Ideath 3	Ectopic pregnanc Other (specify)	ý		23d. Date of c Month	delivery Day Year
ds, P.O.	ires that the de signed by the a I be detached I	þ	Part II. Other significant condition	ons contributing to death	n but not resi	ulting in the u	nderlying cause giv	en in Part I.		obacco use contribute res 2 □ No 3 □	to the cause of death?
Division or Vital Records,	ne law require has been sig ge 2 should b	Completed							24a. Was autop	an 24b. Were	autopsy findings available o completion of cause of
Ta B	sician: The certificate har rector, age		25. Was case referred to medical					26 Place of		rmed? death 270 No 1 ☐ Y	?
Z V	Physician: this certific al director,	To Be	examiner? 1 ☐ Yes 2 D No	Hospital: 1 Inpa		ER/Outpatier		er: 4 🗆 Nursii	ng Horne 5 ☐ Resid	dence 6 □Other (S)	pecify)
ion	inding Phath.	ation:	27. Manner of Death 1	9	njury Day Year)	28b. Time o Injury	Wo	ryat ńk? Yes 2∐No	28d. Describe h	now injury occurred	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 200. Flace of	injury - At ho etc. (Specify		reet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	e Hospi 24 hour e Funer etely fill	Medical		g Physician: To the be Examiner: On the basis and manner	s of examina						
	To th within To th comp	Me	29b. Signature and title of certifier	jaus J.s	1112		29c. Licens	e number	65	29d. Date signed (<i>Mc</i>	
			30. Name and address of person				Print)	ranza	21742		4 =
	2	to	36 & Null 31. Date filed (Month, Day, Year)	Shed-	istrar's Signa	c(Q2)	Ceru re	10	21742		· · · · · ·
	Sta Registr		MOV A	W.	die e	K A	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 24 Month **Physician** 2007 6:25 A M Alvin Lee Fearins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton Ruxton Health of Denton 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 182 M 2□ F Months Days Hours Min. January 10, Director 85 213-18-4419 Usual Residence of Decedent Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Denton Maryland Caroline 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States of America 8151 Harmony Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Be Completed by 3 Widowed 4 ☐ Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Lee Fearins Bessie Mae Torbert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse L. Fearins Son 8040 Lake Drive, Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or pither place)

Maryland Eastern Shore

Veterans Cemetery 10/30/2007 Hurlock, Maryland

22. Name and Address of Eacility

Moore Funeral Home, P.A. 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 'ando ph A 1600 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal fall was /Medical Due to (or as a consequence of): **Examiner** Parkinson's dis advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2000 3 ☐ Probably 4 ☐ Unknown : certifica**te** has b**ee**n si irector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□ No 1∐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: Home 5 Residence 6 Other (Specify) 200 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 136 Lednum Avenue, Preston, Maryland 21655 Melinda Butler, M. . Registrar's Signature 31. Date filed (Month, Day, Year) State (realls) DCT 2 9 2007 Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 17 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 2 2007 2:45A Nov. Pearl Gray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rehab. Washington
If Under 24 Hrs. 8. Date 6
Hours Min. (Mont Fort Washington Health & Prince Georges Fort Center 8. Date of Birth (Month, Day, Year) Feb. 15, 1922 Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 ☐ F Yrs. 85 Director 225-36-5725 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event. If a My Jisal Examiner must be multified at once. tx Yes 2 No Director Fort Washington Md. PG 10g. Citizen of What Country? 10e. Street and Number 12021 Livingston Road 20744 United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private 6 Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elvira Unknown Walter Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11518 Capstan Drive
Upper Marthers, Ad Date 2077

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State Mary A. Shaw/daughter 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Airy Cemetery 11/7/07 Leesville, VA 21. Signal r of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Due to as a consequence of): /Medical arterischentie Carolin vescula- Discon Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? for 5 Other (specify) □Yes 2⊠No P.0. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2**]** No Hospital or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA P 1 ☐ Yes 2 🙀 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

State

Registrar

30. Name and address of part on who complete druse of deal

29b. Signature and title of contifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print) Road

32 Registrar's Signature Endle

		1	For State Registrar	State of Maryla		tificate of L		ientai Hygi Re	eg. No 2	007	36094
# 	Physicia /Medic	an	Decedent's Name (First, Middle, Last)	Olson V.	Gantt			2. Date of Death Month Oct	Day 23, 200	Year 7	3. Time of Death
	Examin	_	4a. Facility Name (If not institution, give str Calvert Memo			Pri	Location of Death ince Frederic	<	4c. Cour	nty of Death Calv	
*	Funeral Director		212-72-3124	7. Age (<i>ln yr</i>	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep 17,			ace (State or Foreign try) 1aryland
Jaryland	f show ed at		Usual Residence of Decedent 10a. State 10b. County MD Calve		City, Town or Lo	cation	Lusby			11	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the N	3a or 28a- t be notifi	I Director	10e. Street and Number 12535 Olivet Road			10f. Zip Code	20657	1	0g. Citizen o	of What Coun	
5-0036	ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	В	lace - America lack, White, o	etc.
21215-0036 d within 72 hours af	e. an "natural' Medical Ex	Completed b	15. Decedent's Educa (Specify only highest grade	Year or Dates: ation completed) College (1-4or 5+)	I (Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work f)	ing	l 16b. Kind of	Business/Ind	dustry
	nd Mental Hygien marked other th matic event, the	Be	12 17. Father's Name (<i>First, Middle, Last</i>)	All 10 11		Cus	todian 18. Mother's Name		Maiden Surn	,	10015
0	is marke raumatic	으	19a. Informant's Name/Relationship (Type Audrey Gantt /Mother	us Albert Gantt, S e. Print)	19b. Mailir	ng Address (Street Box 115 Lush		ral Route Number	Ithea Ba		Code)
ore,	0		20a. Method of Disposition 1. Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		p. Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)		20c. Locatio	n - City or To	
Baltin	Department Important; I any Injury o		21. Signature of Funeral Service Licensee	well		2. Name and Addre Sewell Ft		ad Prince F	rederick.		
E politon	hysician /Medical xaminer	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	requence of):	erge	ailm	or respiratory arr			Approximate interval Between Onset and Death Several Jean,
P.O. Box 68/60,	r the attending physician and ched for use as the burial-transit	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome pf pre 1 \(\subseteq \sub	etal death 3	□Ectopic pregnanc	у			Date of delive	ery Day Year
ds, P.	been signed by the should be detached	by	Part II. Other significant conditions conf	ributing to death but not	resulting in the u	underlying cause giv	en in Part I.	23e. Did to			he cause of death?
Vital Records,	cate has been page 2 shou	Completed						24a. Was a autop perfor	sy	prior to co death?	opsy findings available mpletion of cause of 2 No
Division or Vita	within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	25. Was case referred to medical examiner? 1	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year 28e. Place of injury - A building, etc. (Sp	t home, farm, st	of 28c. Inju	ner: 4 Nursing H	th (Check only or ome 5 Resid 28d. Describe h	ence 6 ow ow injury oc	curred	fy) al Route Number,
	within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer		ician: To the best of my ler: On the basis of exan and manner stated.							
j j	within a To the comple	Med	29b. Signature and title of certifier	nsay	-m	29c. Licens	27189		10.	gned (Month,	2007
teu	7 Sta	ate	30. Name and address of person who could be a second of the second of th	mpleted cause of death (2417	Solos	nons Is	sland	Rd	. Hur	trigtown m) 2067

			For State	State of	f Marylan	-	artment of H ertificate of L		Mental Hyg	iene		
			Registrar 1. Decedent's Name (First, Middle,	Last)		06	runcate of L	Jealli	2. Date of Deat	eg. No. 2 (07	3 5 0 9 5 3. Time of Death
١.	Physici /Medic		10		va O. G	arner			Month	Day at 22, 200	Year 7	7:45 A ^M
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or			4c. County	of Death	
	<u> </u>	1	·	Mill Bridge R	oad 7. Age (In yrs.	last hirthday) If Under 1 Year	Lusby If Under 24 Hrs.	8. Date of Birth			vert ace (State or Foreign
- F	Funeral Director		216-30-4997	1 □ M 2 X F	7. Age (iii yis.	Vrc	Months Days	Hours Min.	(Month, Day,	Year)), 1933	Coun	try) MD
	P		Usual Residence of Decedent						Aug 20	7, 1935	l	
	show	ō	10a. State 10b. County	Calvert	10c. Cit	y, Town or L	ocation	Lughy			10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	rect	10e. Street and Number	Calvert			10f. Zip Code	Lusby	11	Og. Citizen of	What Coun	try?
	h with 23a or st be	a Di	11025 Mill Bridge Ro	ad				20657			U.S.A	١.
	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be norified at	Funeral Director	11. Marital Status	Armed Fo		.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America	
36	rs afte	by F	1 □ Never Married 2 □ Marrie 3 □ XVidowed 4 □ Divorced	ed 1 □ Yes If Yes, Giv Year or Da	re e		1 ☐ Yes 2 ☑ No	Specify:		Specil	y: Blac	k
215-0036	2 hou latura ical E	ted	15. Decedent	s Education		16a. Dec	edent's Usual Occupa	ation	. 1	l 16b. Kind of B	usiness/Ind	lustry
215	ithin 7 ne. nan "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	e kind of work done o DO NOT use retired,		ang		0-1	
21	filed w Hygier Ither th		9 17. Father's Name (<i>First, Middle, L</i>	actl			Dish	washer 18. Mother's Nam	e (First Middle A	Asidan Surna	Cafe	<u> </u>
Maryland	buld be fi Mental H arked ot atic ever	o Be	17. Famer's Name (First, Wildure, L	Fred	Harrod			TO. MOUTER'S NATH		lary Park	,	
ary	S D E E	2	19a. Informant's Name/Relationsh			19b. Mai	ling Address (Street a	and Number or Ru		·		Code)
	1 and 2 Health a em 27 is		April Garner /Daug	hter			D. Box 604 Lus		7			
altimore,	ges 1 t of H if iten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from	State 20b. F	Place of Disp cemetery, cri	osition (Name of ematory or other place	e)	Date	20c. Location	- City or To	wn, State
<u>=</u>	it. Paritmen		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L				wn's Cemetery 22. Name and Addres	<u>.</u>	0/26/07	Po	ort Repu	blic, MD
Ba	permit. Pages 1 and Department of Health important: If Item 27 any Injury or other to		Maden A	Levell	7	'	Sewell F	uneral Home			MD 200	270
ž			23a. Part1, Enter the disease, or a shock, or heart failure. List of	complications that c	aused the deat	h. Do not er		res Beach R g, such as cardiac			JVID ZUR	Approximate Interval Between
	Physician	i h	Immediate Cause (Final disease or condition	. CA	12.	and	iv					Onset and Death 2 May
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					7	7 7 00 00
	100	-	Sequentially list conditions,	b. Due to (or as a conseq	uence of):					-	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,						
/60,	e exectan an		resulting in death) Last	Due to (or as a conseq	uence of);						
9/8	icate be executed physician and the burial-transit	dical	,	d								
X 6		/Me	IF FEMALE:	23c. If yes, out	come pf pregna	ancy				23d D:	ate of delive	n/
. Box	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live b	oirth 2□Feta nantattime of d	death 3	☐Ectopic pregnancy ☐ Other (specify)				onth	Day Year
J.	at the by the tache	hys	9 ☐ Unknown	9□Unkno								
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the	underlying cause give	n in Part I.		acco use con		e cause of death? ably 4 □Unknown
Records,	requi	Completed	Mayers									
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VItal		င်	25. Was case referred to medical				24(6.00)	26. Place of Deal	1 Yes 2 th (Check only on	2 No	1 ☐ Yes	2 No
	S 0 =	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🔲 I	npatient 2	ER/Outpatie	ent 3 DOA Othe		ome 5 Reside		her (Specif)	1)
n or	ding Phy h. After thi funeral o		27. Manner of Death 1. □ Natural 5 □ Pending		of Injury th, Day Year)	28b. Time Injury	Work		28d. Describe ho	w injury occu	rred	
DIVISION	ttend death. ctor: / the f	icati	2 Accident investiga 3 Suicide 6 Could n	ation ot be	of injury - At he	ome farm s	M 1 □ `treet, factory, office	res 2□No	28f. Location (St	reet and Num	her or Rura	I Boute Number
<u>≥</u>	pital or Al	Certification:	4 ☐ Homicide determin	ned buildi	ng, etc. (Specif	y)	area radiony, emice		City or Town	, State)	Der or riura	Triodic Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 CertifyIng	Physician: To the	best of my kno	wledge, dea	ath occurred at the time	ne, date and place	and due to the car	ause(s) and m	nanner as si	ated.
	To the Hos within 24 ho To the Fun completely	Medical	one)	and mani	ner stated.	- and or	29c. License					
	o viti		29b. Signature and title of certifier	7			DVA	3301	, 2	9d. Date sign	2 S	Day, Year)
,	.		30. Name and address of person v	vho/completed caus	e of death (Iten	n 23a) (Tvne	, Print)	500 0			23/1	/ /
ζW	2		Sylvia Bongers Ba				an Road Lusby	, MD 20657				
	Sta		31. Date filed (Month. Dav. Year)	32. R	egistra Signa	ature	Spects.					
	Registr	ar	001	P 2 F001	MAN	a St	AND BACK					

DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of Ma	,		rtificate of		•	Reg. No. 7	0.7	3 < 0 0 6
8.	¢ Dhuaisi		1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of Death
1	Physicia /Medic	-	Wauneta Virgin	ia Griffith					October		2007	0330 AM
	Examin		4a. Facility Name (If not institution, g.				4b. City, Town, o	or Location of Deat	h	4c. County		
7			Washington Count 5. Social Security Number 6.		o (In uro Is	ast birthday)	Hagers If Under 1 Year	town If Under 24 Hrs	8. Date of Bir		i ngtor	ace (State or Foreign
	Funeral Director		215-20-8660	1 M 2 X F	83	Yrs.	Months Days	Hours Min.		y, Year)	Count	ry)
*2	No. 46		Usual Residence of Decedent						Jail. /	1724		
	arylan show d at	_	10a. State 10b. County		10c. City	, Town or Lo	ocation				10	0d. Inside City Limits 1 ☐ Yes 2 💢 No
	ne Ma 8a-f s	ecto	Maryland Washing	gton	Sha	arpsbu	<u> </u>					
	with the	Funeral Director	10e. Street and Number 4824 Harpers Feri	ev Pood			10f. Zip Code 2178	22		10g. Citizen of V USA	vnat Count	ry?
	leath	eral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.			Specify Yes or No		e - America	an Indian,
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an', Mexican, Puèi Specify:	to Rićan, etc.)	Blac Specify	k, White, e	
5-0	72 hc 'natu dical	Completed	15. Decedent's (Specify only highest of	Education trade completed)	I	(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of Bu	usiness/Indi	ustry
121	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or s	5+)		DO NOT use retire Welder	ed) _		Aircraf	+ Man	ufacturer
2	e filed v al Hygie other t vent, th		8 17. Father's Name (First, Middle, La	st)		Spoi	werder	18. Mother's Na	me (First, Middle			uracrurer
an	ould be in Mental narked o	To Be	George Perry Kn	,					lorence		,	
ary	should and Men marke umatic	-	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	-			State, Zip	Code)
ž	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Nelson W. Knight	- Son		4826	Harpers	Ferry Rd	. Sharp	sburg,MD	2178	82
ore	0 0		20a. Method of Disposition 1X Burial 2 Cremation 3	□Removal from State		ace of Dispo emetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location -	City or Tov	wn, State
Ĕ			4 Donation 5 Other (Spec				Cemetery		1-2007	Sharpsbu	urg,Ma	aryland
Sali	permit. Pa Departmen Important: any injury once,		21. Signature of Huneral S	fisee (///			2. Name and Addre	U:	sborne F			
	20 2 6 0		23a. Fartt. Enter the disease, or co	mplications that caused	d the death	Do not an	25 S.Cond	ococheagi	ue St.	<u>Villiams</u>	port,	MD 21795 Approximate
			23a. Fartt. Enter the disease, or co shock, or heart ailure. List on Immediate Cause (Final							rreat,		Interval Between Onset and Death
9	Physician		Time Cado (Time			1/ 10	1000	1 2 2 2				
7			disease or condition resulting in death)				NARY 1	TOURST				30 mm.
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequ	ence of):	NARY 1	HULES T				
	/Medical Examiner	ner	resulting in death)	Due to (or as	a consequ	ence of):						lwcek
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90,	/Medical Examiner	If Examiner	resulting in death)	Due to (or as	a conseque a conseque a conseque	vence of): ONIA vence ory. ON				ENSE 1		lwcek
8760,	/Medical Examiner hysician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a conseque a conseque a conseque	vence of): ONIA vence ory. ON				EMSE (lwcek
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#31, perDVR G873, 11/13/07 WS
State of Maryland, Department of Health and Mental Hygiene 2 0 7 36097 For State Registral Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 8=28 PM 5 2007 Harrison Navember Bett 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Harkord Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Month, Day Year) 04/13/1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Telinois 1 ☐ M 2 🔀 F Yrs 85 332-18-3978 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 X No Havre de Grace Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21078 316 Native Dancer Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Traveler Adventurer 0 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dorothy Taylor Daniel Balzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 316 Native Dancer Circle, Havre de Grace, MD 21078 Lawrence Harrison (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition R.A. Ferris & Co., Inc. 11/07/2007 West Chester, PA 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 23 S. Washington St., Havne de Grace,
Sa Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

A shock, or heart failure. List only one cause on each line. MD 21078 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction . Myocardial Acute Due to (or as a consequence of): pronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): iongestire Due to (or a a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ✓ es 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner ox 68760, April no certificate be executed physician and the burial-transit 68760, as attending Box esn nse ò signed by the a P.0. of Vital Records, certificate has been si rector, page 2 should funeral director After t Division or Attending after death.

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Certification:

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7 is marked other than "naturel", or Items 23s or 28s-1 show traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If Item 27 is marked othe any injury or other traumatic event, once.

Physician

with the Manyland

within 72 hours after death

Maryland 21215-0036

Baltimore,

3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0057456 November 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mades Unign Ave., Haure de Grace, Maryland 21078 Kerin 501 S. July Di 31. Date filed (Month, Day, Year)

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State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5 **,** 2007 **Physician** 10:00 P.M November Hessong Evelyn Regina /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Smithsburg 3530 Garfield Rd. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 2 , 1925 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕶 F 82 Maryland 219-20-4858 Director Usual Residence of Decedent 10d, Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 🛣 No Director Md. Frederick Smithsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3530 Garfield Rd. 21783 $U_{\bullet}S_{\bullet}A$ Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H item 27 is marked oth Be Tra Leon Wolf Nellie Lenora Wolfe မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an ant: If item 27 is r Charles W. Hessong (Husband) 3530 Garfield Rd. Smithsburg, Md. 21783 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition St. Mark's Lutheran Nov. 10, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury or once. Wolfsville,Md. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Church Cemetery 22. Name and Address of Facility 12525 Bradbury Ave. 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home Smithsburg, Md. 21783 MO1414 LAVIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence 1): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it among the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No has certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this Director: After th 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) To the Hospital or Attending Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Funeral I 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier DO054451 November 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Smithibo 22911 Jefferson oulevard strar's Signature 32. Regi 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydrene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day BETTY JANE HEFFNER NOVEMBER 2, 2007 9:34 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, You Ct. 24, If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Social Security Number 6. Sex 9. Birthplace (State or Foreign Yea 1924 Days Hours Months Min 219-12-0693 83 1 □ M 2 🗓 F Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County Maryland Frederick Frederick 1 XYes 2 No 10f. Zip Code 21701 10g. Citizen of What Country? 2 East Fourth Street, Apt. 3 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Final Examiner Clothing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Heffner Minnie Leah Harding 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patsy Hall, cousin 17311 Naylor Road, Sabillasville, MD 21780 20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory Nov. 4, 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ford PA Funeral Home 3 A MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of UCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Pneumonia Due to (or as a consequence of): IE FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1□ Yes 2D No 9□ Unknowh Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 ☐ Unknown 1 □ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

physician and the burial-trans Box 68760, death certificate be as t attending p for use as P.O. I signed by the a Division or Vital Records, has page certificate or Attending Physician: After this death. within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital

Examiner Physician/Medical Completed by Be 2 Medical Certification:

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show be notified at

items 23a or

"natural", or item edi. ai Examiner n

the Medical

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant 27 is marked other than "natural", or items 23.

permit. Pages 1
Department of IImportant: if ite
any Injury or ot

Physician

Examine

/Medical

altimore, Maryland 21215-0036

must

Director

by Funeral

Completed

Be

25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

0035106

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myung Lee Nam, M.D., 400 West 7th Street, Frederick, MD 21701

Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2007



Physician Medical Saminer Tomas More Caroly Edit H. Hopkins Howard October 22, 2007 7:10 Spring Thomas More Durwing and the Copy of the C			•	1 - State Registrar	-	partment of Health a ertificate of Death		ene 2007 36100						
Continued Cont		Physici	an	Decedent's Name (First, Middle, Last)	th Harlin - Harr		2. Date of Death Month	Day Year 3. Time ot Death						
Common C		/Media	cal	4a. Facility Name (If not institution, give street a St. Thomas More Nurs Rehabilitation Cent	and number)	4b. City, Town, or Location of Hyattsville	Death	4c. County of Deeth Prince Georges						
Maryland Prince Georges Hyattsville 100. Ze Come 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States 100. Chill rus Road; Apt. 106 20.782 United States				578-52-9844 ^{1□ M 2}	- ∀ r-	Months Days Hours	Min. (Month, Day, Y	Year 1938 9. Birthplace (State or Foreign Country) Washington, D.C						
The proper is the proper of the proper in the proper in the proper in the proper in the proper in the proper in the proper in the proper in th	-0036	nours after death with the Maryland usel", or Hems 23a or 28e-f show Examility at Examility at	d by Funeral Director	10a. State	rges Hyatt Apt. 106 Is Decedent Ever in U.S. med Forces? Yes 2 M No res, Give ar or Dates:	10f. Zip Code 20782 3. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	Unin? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black						
The state of the s	1215-	vithin 72 ne. hen "nat	mplete	(Specify only highest grade comp Elementary/Secondary (0-12) Co	oleted) (G lift llege (1-4or 5+)	ive kind of work done during most e. DO NOT use retired)	of working	Walter Reed Day						
The state of the s	Maryland	uld be filed v Mental Hygie irked other t itic event, th	Be	17. Father's Name (First, Middle, Last)	Cn1	18. Mother	r's Name (First, Middle, Ma	aiden Sumame)						
Physician / Medical Examiner Physic		emit. Pages 1 and 2 shot bepartment of Health and M mportent: If item 27 is mai ny injury or other treumal 0029.		Kevin Renard Taylor (20a. Method of Disposition 1 ABurial 2 Cremation 3 Remove 1 Denation 5 Other (Specify)	(Husband) 601 al from State 20b. Place of ocemetery, Marylan	Audrey Lane; Apt sposition (Name of crematory or other place) d National Memoral 22. Name and Address of Facility R. N. Horton Con	ct. 201; Oxon ct. 29,2007 rial Park La	Hill, Maryland 20745 C. Location - City or Town, State aurel, P.G.Co.Maryland ians, Inc.						
FFEMALE: 23b. Was decoded pregnant in the past 12 months? 1 Ves 2 No	8760,	/Medical Examiner physician and the purial-transit	Physician/Medicai	Examiner	dicai	dicai	dlcai	dlcai		shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Se on each line. Oue to for as a consequence of): Oue to (or as a consequence of): Oue to (or as a consequence of):	enter the mode of dying, such as a solice of a solice	CHICA CAISE	Interval Between Onset and Death Case year)
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25. Was case reterred to medical examiner? 1	ords, F	equires tha sen signed ould be de		ed by P	ted by P	ted by P	ted by P	Part It. Other significent conditions contributions	ng to death out not resulting in the	e underlying cause given in Part I.				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of payson who completed cause of death (Item 23a) (Type, Print) 35c3 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of payson who completed cause of death (Item 23a) (Type, Print) 35c3 25c3 25c	I Rec	The law a cate has by page 2 sh	Comple	Cesemoro	W Collar	disease	autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No						
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of payson who completed cause of death (Item 23a) (Type, Print) 35c3 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of payson who completed cause of death (Item 23a) (Type, Print) 35c3 25c3 25c	ivision of Vita	Attending Physicien: or death, ector: After this certific by the tuneral director,	To Be	To Be	To Be	To Be	examiner? 1 Yes 25 0 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 286	Date of Injury (Month, Day Year) Place of Injury - At home, farm	tient 3 DOA Other: 4 Nur e of 28c. tnjury at ty M 1 Yes 2 N	rsing Home 5 Resident 28d. Describe how No 28t. Location (Stre	ce 6 Other (Specify) r injury occurred eet and Number or Rural Route Number,			
30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 3503 (EVSY State) 31. Date tiled (Month, Day, Year) 32. Registrar's Signature	0	Hospitel of the Pours all Funerel Distriction itely filled in	Jical Ce	(Check only 2/ Medicel Exeminer: O	n the basis of examination and/o	eath occurred at the time, date and r investigation, in my opinion, deat	d place, and due to the cau h occurred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)						
State 31. Date tiled (Month, Day, Year) 32. Registrar's Signature		To the somple comple	Mec	29b. Signature and title of certifier	P. Tuli	D1960	²⁹⁰ (d. Date signed (Month. Day, Year)						
	R	Sta	ate	3503 PEXTY	Street- 1	result Rais	HEY MI)	20712						

DHMH 17 Rev 1/2001

9:05 a M

Birthplace (State or Foreign Country)

Black

Day

20785

Year

10d. Inside City Limits

1XTYes 2 □ No

24, 2007

Oct.

Physician /Medical **Examiner**

Velma

Barbara

Haughton

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at "natural", or items 23a or er than "natur , the Medical Important: If item 27 any injury or other to once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

certificate be executed burial-tran and physician the as attending ō s been signed by the should be detached has page 2 certificate Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dli this

Box 68760.

P.O.

Division or Vital Records,

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Mitchellville Prince George's 11212 Lake Vista Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 💢 F 75 18, 1931 Kingston, Jamaica 219-64-3486 Usual Residence of Decedent 10c. City, Town or Location 10a. State Director Maryland | Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 USA 11212 Lake Vista Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∏Yes 2X∑No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Completed by 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mt. Rainier Early Elementary/Secondary (0-12) College (1-4or 5+) Childhood Center Day Care Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rudolph McDonald Rita McLennan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Haughton - Daughter 11212 Lake Vista Lane, Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 10/30/07 Adelphi, Maryland 4 Domation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lines 22. Name and Address of Facility 4739 Baltimore Ave Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MOINA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final) Metastatic Pancreatic Cancer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 [X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier maxane MO 10/24/07 D16619 Gelek

State

8200 Professional Pl., Ste #104, Landover, MD

30. Name and ad this of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Vergara-Soares

	·	For State Registrar	State	e of Ma	ryland		rtment tificate			Mental Hygi	iene g. No. 1	07	36102
Physic		Decedent's Name (First, Mide		an Lo	uise	Jones				2. Date of Death Month Day Y		Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not instituti			own, or	Location of Death		4c. County of De		1010			
	-		Memorial H		/In use las	at hirthday)	If Under 1		nce Frederic If Under 24 Hrs.	k 8. Date of Birth		Calv	vert place (State or Foreign
Funeral Director		5. Social Security Number 579-26-7530	1 M 2 X		(In yrs. las	Yrs.		Days	Hours Min.	(Month, Day,		Coul	ntry) MD
3 -		Usual Residence of Decedent	1		10- 01-	T				ividy 0,	1021		
larylar show	J.	10a. State 10b. Count	y Calvert		10c. City,	, Town or Location 10d. Inside City Dunkirk 1 □ Yes 2							1 ☐ Yes 2 🛣 No
the M 28a-f notifie	Director	10e, Street and Number	Calvert]			10f. Zip (Code	- Dulikirk	10	Og. Citizen of	f What Cour	ntry?
h with 23a or st be	a Di	9925 Kirksvillle Lane							20754			U.S.A	
r deat ems 2	Funeral	11. Marital Status	12. Was	Decedent E d Forces?	ver in U.S.	. 13. V	Vas Decede Yes, speci	ent of His	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ace - Americ	
And yid it a first 13-0030 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Ma 3X Widowed 4 ☐ Divorce	If Yes	es 2 ☑ N , Give or Dates:	lo	1	☐ Yes 2	K No	Specify:		Spec	ify: Black	(
2 hour	ted	15. Decede	ent's Education			16a. Deced	ent's Usual	Occupa	ation Juring most of work	una -	 16b. Kind of	Business/In	dustry
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d be fi	o Be	17. Father's Name (First, Widdle		Harve	v				TO. MODIE: 3 Nan	Mary Eli:			
shoul and Ma	ြင	19a. Informant's Name/Relation				19b. Mailin	g Address ((Street a	and Number or Ru	ral Route Number			o Code)
and 2 ealth a n 27 is		Wilbert M. Jones /S	Son						e Dunkirk, M				
Deficition by India yial to A 1.50030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 □Removal f	rom State	20b. Pla	ce of Dispos metery, cren	sition (Name natory or oti	e of her plac			20c. Location	-	
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Dermit Depart Important In any Irr		1 Sladen	J. Sey	ell			Sew	ell Fu	neral Home	ad Prince Fr	adarick l	MD 208.	78
検		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications t	hat caused on each lin	the death.	Do not ente						VID ZOO	Approximate Interval Between
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law requires t as Leen signe 2 should be o	Completed by	TIME OSCI	2/0/15	0010		0000	corco		7,00	24a. Was a	n 24t	. Were auto	opsy findings available
he far e has ge 2	dwo	-								autops perfori	ned?	prior to co death?	ompletion of cause of 2 No
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r Attending for death. irector: After by the fune	ficat	3 Suicide 6 Coul	d not be 28e. I	Place of inju	ıry - At hon	ne, farm, stre			100 2 3110	28f. Location (Si	reet and Nur	nber or Rur	ral Route Number,
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificae has completely filled in by the funeral director, page 2	edical		al Examiner: On		examination					e, and due to the curred at the time, o			
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. 1		30. Name and address of person	on who completed	cause of de	eath (Item 2	23a) (Type,	_	TYA	N.C.	510124	ANG	D	ti
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State of Maryland / Department of Health and Mental Hygiene? [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Sarah Johnson October 28, 2007 6:00 P. M Janice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 348 Nottingham Road Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 84 Director Yrs 217-12-2269 August 19,1923 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I7 is marked other than "neturel", or iteme 23a or 28a-f ehow treumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 348 Nottingham Road 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🗙 No δ Specify: White **¾**□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dress Manufacturer 8 Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ss 1 and 2 should be first Health and Mental Filtem 27 is marked of Clyde Chrisman Nettie May Easterday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14710 National Pike, Clear Spring, Maryland 21722 Mary V. Huff Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If Iter
eny Injury or oth Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10-31-07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. R hoel Brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and De the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) mulis mala **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by I should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 ₽No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? certificete 2 D No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only on Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပု 1 Yes 2 No this After thi 28b. Time of Injury 27. Mann eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 36651 m_{l} cause of death (Item 23a) (Ty ..., Print) HAGUITOWN, STILL! hale 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Baltimore, Maryland 21215-0036	# 5 F	by Funeral Director	1 ☐ Never Married		Armed Forces' 1 ☐ Yes 2 [X] If Yes, Give Year or Dates:	? No				Specify:Puet			ck, White, y: Whit		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 123a State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 16b per FH Certificate of Death Red. No. 16b per FH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav MORTON SR. 21, 2007 KIRK 9:10 AM ROBERT Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/9/1926 Bel Air 5. Social Security Number 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** 219-18-4932 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-diral Examiner must be notified at 10b. County 1 ☐ Yes 2 No Directo Harford MD. Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1819 Baldwin Mill Road 21050 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Shett Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nyle Morton Estella Woodall 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 (Wife) 1819 Baldwin Mill Rd. Virginia C. Morton Forest Hill, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cem. 10/26/07 Owings Mills, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Service/Licensee E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that daised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 20/2014 resulting in death) /Medical Due to (or as a consequence of): TON APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury Duc to (or as a consequence of Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CERTIFIC IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has e 2 s autopsy page death2 1 des 2 No perform Moston Vital certificate 2 No Be 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Hospital: 1 hpatient 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 30 2 2 ER/Outpatient 3 DOA After this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation rai 2 Accident Multiple falls Unknown Unknown 1 Yes 2 No death. within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Unknown the Hospitai 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of cenifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kurton DO. 500 upper Chesapeake Dr. Bel Air, mo 2/014 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCT 24 2007 1430 **Physician** Alma Katherine Monnett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Calvert Memorial Hospital Prince Frederick Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days 1 □ M 2 😿 F 218-42-9727 90 Oct 7 1917 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show at 1 ☐ Yes 2 ☑ No 28a-f sh notified Prince Frederick Maryland Calvert Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or United States 20678 930 Main Street 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items ' 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 TxMarried 1 ☐ Yes 2 No Specify: Speciwhite Completed by 3 Widowed 4 Divorced the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 7th 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) Be Katherine Deborah Bowen Robert Lee Ogden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 186 Prince Frederick, MD 20678 Carolyn DeBolt- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any Injury or once. Central cemetery Oct 27 2007 Barstow Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) ract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown Renal Failure. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Cardio Vasular disease Athenoscienolic 1□ Yes 2☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28b. Time of 28d. Describe how injury occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

death

Baltimore, Maryland 21215-0036

27. Man or of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 50653

dew State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Murchton Deale 851

GYAN C. SURANA

Road Deale MD.

Registrar

32. Registra Signature 31. Date filed (Month, Day, Year) 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month October 22, 2007 **Physician** William Oliver MacArthur, Jr. 3:04 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1**∑**M 2□F 212-40-5735 65 10/21/1942 Arkansas Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☑ No Examiner must be notified MD Calvert Lusby Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 20657 United States 2015 Sandia Court or items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2√2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) Commerical Insurance 4 Insurance Broker is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Oliver MacArthur Phyllis Lehew ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health an 2015 Sandia Court, Lusby, Maryland 20657 Lucinda L. MacArthur (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/24/07 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licentee Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-tra Due to (or as a cor attending physician for use as the buria Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ № 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 NO 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Physician: this After or Attending 24 hours after death Funeral Director: filled in by the Hospital within 24 hou

To the Fune

completely fi

within 72 hours after death

2 should be filed within and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manoj Mathur, M.D. 110 Hospital Rd; Suite #305, Prince Frederick, Maryland 20678

29d. Date signed (Month, Day, Year)

3

2007 Signature 31. Date filed (Month, Day, 24 OCT

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D006194

			1- For Amend Items Registrar	State of Mary 2	3,27,282 Cer	rtment of tificate o	Health and Death	1/69/69/84	pjene Rog. No 200	7 36108	
	Division		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ath Day Ye	3. Time of Death	
	Physici /Medio		William	McDuffie	JR			04		07 1:45 P ^M	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of Dea	ath	4c. County of D	Death	
			Heartland Health			Hyatts	sville, Ma	aryland	Prince	Georges	
п	Funeral		5. Social Security Number 6. Se	7. Age <i>(In y</i> XIM 2□ F 6	7 Yrs.	If Under 1 Ye Months Da			y Year) 9.	Birthplace (State or Foreign Country)	
L	Director		579-50-5999 Usual Residence of Decedent		113.			04-09-	1940 Wa	shington, D C	
	/land		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits	
	Many fied	ţō	D C	Wa	ashingto	n				1X Yes 2 ☐ No	
	h the	rec	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of Wha	t Country?	
	th wit	Funeral Director	415 Irving Stree	t N W		200	010		USA		
	dea	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13. V		of Hispanic Origin? (Cuban, Mexican, Pue	(Specify Yes or No-		Americen Indian, Vhite, etc.	
90	or it	F	1 ☐ Never Married 2 ☐ XMarried	1 ☐ Yes 2 ☒ No If Yes, Give		Tou, spoonly 0		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:		
8	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examiner matte multified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Black	
15-	"nat	Completed	15. Decedent's Ed (Specify only highest grades)		(Give	lent's Usual Oc kind of work do DO NOT use rei	ne during most of w	orking	16b. Kind of Busine	ess/Industry	
12	within ene. than "	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)					Connition	+ Onical Ca	
7	il Hygie other	Ö	17. Father's Name (First, Middle, Last)		C	ourier	18. Mother's N	ame (First, Middle,		t Opical Co	
<u>a</u> n	ld be ental ked o	To Be	William McDuffi	e Sr.			Edith	Maggin			
Maryland 21215-0036	shou ond N mar	-	19a. Informant's Name/Relationship (7				eet and Number or F	Rural Route Numbe	r, City or Town, Sta		
Σ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. Ite Medical Examiner rival be inclifted at		Catherine McDuf	fie (Wife)	2359	Ainger	PI S E Wa	shington	, D C 2002	20	
ore	iges 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐		. Place of Dispos cemetery, crem	sition (Name of	place)	Date	20c. Location - City	or Town, State	
Baltimore,	permit. Pages Department of I important: If it any injury or o		4 □ Donation 5 □ Other (Specify	Ri	iverdale			/04/07	Riverdale	e Maryland	
3alt	Depart Import Import Injour		21. Signature of Funeral Service Licen	500	22.	. Name and Ad	dress of Facility A U	stin Roys	ster Fune	ral Home	
_	00 E 8 0		1 Jet						nington,D		
			23a. Part1. Enter the disease, or comp shock, or hear failure. List only	lications that caused the de one cause on each line.	eath. Do not ente	er the mode of o	dying, such as cardi	ac or respiratory ari	rest,	Approximate Interval Between Onser and Death	
	Physician /Medical		Immediate Causé (Final disease or condition resulting in death)	a. Seizure D	isorder	Head Ir	ijuries v	vith Comp	lications		
H	Examiner			Due to (or as a cons	sequence of):			. 1/	at our		
	*	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence oi):		- A - F	The P	MINA		
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C			111	BY MEDICAL!	Ekri		
Ö,	e exe ian ar iriai-t		resulting in death) Last	Due to (or as a cons	equence of):		TICATION APP				
8760,	Attending Physician: The law requires that the death certificate be executed rideal. rideal. consists a conflictate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical									
9 x	entifica ding ph	Physician/Med	IF FEMALE:	22- 14							
Вох	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregna			23d. Date of Month	delivery Day Year	
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time o 9□ Unknown	rdeath 5	Other (specify,					
	es that the death certific igned by the attending p be detached for use as		Part II. Other significant conditions co	ntributing to death but not i	resulting in the un	derlying cause	given in Part I.	23e. Did to	bacco use contribut	te to the cause of death?	
g	quires n sign	d by		ollitus				1 🗆 Y	'es 2 □ No 3 □	Probably 4 Unknown	
<u>S</u>	w require been sig should b	lete	D (abcccs - n	CTTTOGS				24a. Was a	an 24b Were	e autopsy findings available	
æ	The lay te has age 2	Completed	-HIW	.1 5-21				autop: perfor	sy prior med? deat	to completion of cause of h?	
ta	en: tifica tor, p	0	25. Was case referred to medical	nal Failure			26 Place of De	1 ☐ Yes eath (Check only or	A	Yes 2□ No	
>	ding Physician: The h. h. After this certificate ha funeral director, page	ToB	examiner? 1XYes 2 XNo	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA	Other		ence 6 Other (S	Specify)	
0	ng Pt Iter tf neral		27. Manner of Death 1-	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. lr	njury at Vork?	28d. Describe h			
Sio	ttendil death. ctor: A the fu	Satio	2X Accident investigation	Unknown	Unknow	n. M	□Yes 2 No		fell down		
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (S City or Tow	28f. Location (Street and Number of Rural Route Number, City or Town, State) 415 Irving St.		
	_ = - =			Steps in fr				N.W. W	ashington	D.C.	
	pita ours eral	_		sician: To the best of my k	nowledge, death ination and/or inv	occurred at the estigation, in m	e time, date and place by opinion, death occ	ce, and due to the courred at the time, of	ause(s) and manne date and place, and		
	Hospita 24 hours Funeral stely filled	lcal	(Check only 2 Medical Exam	and manner stated						r as stated. due to the cause(s)	
	o the Hospital	Medical	(Check only one) 2 Medical Exam 29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number	2	29d. Date signed (M	due to the cause(s)	
)	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	and manner stated.						due to the cause(s)	
(To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Exam	and manner stated.	tem 23a) (Tvpe F	D-(onse number 006530		29d. Date signed (M April 25,	due to the cause(s)	
(To the Hospital within 24 hours To the Funeral completely filled	Medical	29b. Signature and title of certifier 30. Name and address of person who c	ompleted cause of death (III	igas Roa	D-(Print) Id Hvati	006530		April 25,	due to the cause(s)	
(To the Hospite Within 24 hours To the Euneral completely filled	te	29b. Signature and title of certifier 30. Name and address of person who c	and manner stated.	igas Roa	D-(Print) Id Hvati			April 25,	due to the cause(s)	

DHMH 17 Rev 1/2001

			1 - For State	State of M	laryland	/ Depa	artment of F	lealth and M			36109	
		-	1. Decedent's Name (First, Middle	a. Last)		061	illicate of	Dealii	2. Date of Death	g. No.	3. Time of Death	
	Physici		Lewis Richard						Month	Day Year 27, 2007		
1	/Medi Examir		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death	OCCODEL	4c. County of Dea	5:30 p.m.	
	Lxaiiii		12012 Nationa	1 Pike			Clear S			Washin	gton	
	Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Bir	thplace (State or Foreign	
г	Director		214-34-7664	1 M 2□ F	70	Yrs.	Months Days	Hours Min.	(Month, Day, Nov. 18	, 1936 Ma	ountry)	
	D .		Usual Residence of Decedent 10a. State 10b. County		10+ Cit. 3	T						
	aryla •ho	5			10c. City, 7	IOWN OF LO	cation				10d. Inside City Limits	
	he N	Director	Maryland Washi	ngton	C1e	ear S				1 ☐ Yes 2 💆 N		
	with						10f. Zip Code		10	g. Citizen of What C	ountry?	
	eath	era	12136 Big Pool	Road 12. Was Deceden	t Ever in II S	13.1		21722 lispanic Origin? (Spe	noity Voc or No.	USA 14. Race - American Indian,		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Exertinar must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Marr	Armed Forces ied 1 ☐ Yes 2 ☐ If Yes, Give	? {No	1	Yes, specify Cuba	Specify:	Rican, etc.)	Black, Whi	te, etc.	
21215-0036	hour tural	g pe	3 Widowed 4 Divorced	Year or Dates				-11			White	
5	in 72	Completed	15. Deceden (Specify only highes	t grade completed)		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	6b. Kind of Business	Industry	
72	with the	mo	Elementary/Secondary (0-12)	College (1-4or	5+)		chanic	~		A		
D	Hyg other	BeC	17. Father's Name (First, Middle,			110	Inalite	18. Mother's Name	e (First, Middle, M	Auto aiden Sumame)		
a	ild be lental ked ic ev	To B	George Frankli	n Murray				Daisy Ma	a Rotte			
Maryland	shot and N ma		19a. Informant's Name/Relations	-		19b. Mailin	g Address (Street			City or Town, State,	Zip Code)	
Σ	and 2 alth a 127 l		Dakota Murray	- Wife		12136	Big Poo	1 Road, (Clear Spr	ing. Marv	land 21722	
ore	of He		20a. Method of Disposition	2 Demond from State	com	e of Dispo	sition (Name of natory or other place			0c. Location - City or		
altimore,	Pag nent ant: I		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (S)			-		ory 10/29	/07 н	agerstown	. Maryland	
ä	eperti eperti port y inj		21. Signature of Funeral Service	nnich Fu	neral Hom	e						
<u> </u>	20E 20		23a. Part 1. Enter the disease, or	town, Md.	21740							
П			st,	Approximate Interval Between								
*	Physician		Immediate Cause (Final disease or condition	Aden	Scarc	2 10	oma E	F 8,500	haque	ith metas	Onset and Death	
	/Medical Examiner		resulting in death)		s a consequer	nce of):		· O Spep	They have	111 1100 100	VICINIS	
)	er	Sequentially list conditions,	b. Due to for a	an of).							
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequer	ice or):						
	s be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as	s a consequen	nce of):						
8760,	cate be executed physician and the burial-transit	dical		d=								
89												
ŏ	death certifi e attending id for use as	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy		F -11			23d. Date of de	ivery	
m m	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Ectopic pregnancy Other (specify)			Month	Day Year	
o.	that the de led by the a detached f	hys	9 🗆 Unknown	9□ Unknown								
ທົ	9 20	þ	Part II. Other significant condition	ns contributing to death I	but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
ord	w requir been si should	ted	Heure CVH	, CAD,	COPI	7			1 🗆 Yes	2 2 No 3 P	obably 4 Unknown	
Vital Records,		Completed							24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of	
<u> </u>	ian: The taw rtificete has l tor, page 2 s	Ö							performe 1 ☐ Yes 2	do death? No 1 ☐ Yes		
<u> </u>	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			100	26. Place of Death	(Check only one)		1. 10.10	
ō	this al die	은	1 Yes 2 No 27. Manner of Leath	1 ∐Inpati		/Outpatient		4 Nursing Hor	me 5 🗆 Residen		city) daught	
5	5 E	io	1 Natural 5 ☐ Pending	28a. Date of Inju	ay Year)	lb. Time of Injury	28c. Injury Work M 1 🗆		28d. Describe how	injury occurred	M850=84.039	
DIVISION	Attanding r death. ector: After by the fune	licat	3 Suicide 6 Could n	of be	iury - At home	farm etra	et, factory, office	Yes 2 □ No	Of Location (Stro	et and Number or Ru	um I Courte Mumber	
2	tal or Attandii s after death. al Director: A ed in by the fu	Certification:	4 Homicide determine	building, e	tc. (Specify)	, iaiii, siie	et, lactory, office	'	City or Town,	State)	Irai Houle Number,	
	id and	29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the (Check only only only only only only only only									stated.	
	ne Hos n 24 h ne Fun bletely	edicai	(Check only 2 Medical E	xaminer: On the basis of and manner si	or examination	and/or inv	estigation, in my op	oinion, death occurre	ed at the time, date	e and place, and due	to the cause(s)	
	To the within 2 To the complet	¥	29b. Signature and title of certifier	dM		3	29c. License	number	290	J. Date signed (Mont	h, Day, Year)	
			> Xulla	10 /al	1mm	5	Noc	ソクスンニ	33	10/29/	07	
2			30. Name and address of person	vho mplet use of	death (Item 23	Ba) (Type, F	Print)			-10/1		
H	-6		580 North	ern Au	e (tas	erstou	on m	Dai	742		
	Sta		31. Date filed (Month, Day, Year) OCT 3	32. Regist	rar's Signature	h A						
	Registra	al .	96101	J GUU! SERE	tion of	To Jan	SEL ASSESSMENT					

DHMH 17 Rev 1/2001

Physician /Medical Examiner-

attending physician

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a must

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

sladys M. Mills 214-34-6396

Division or Vital Records, P.O. Box 68760,

Physician:

this

within 24 hours a To the Funeral D

BA 8

the

with ò

be notified

Director

Funeral

2

Completed

Be

VA

cate has been signed by page 2 should be detacl Plospital or Attending Pl 24 hours are death. Funeral Director: After the felly filled in by the funeral Medical

Examine Physician/Medical IF FEMALE 9 ☐ Unknowr þ Completed 25. Was case referred to medical Be 2□ No

2 Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

24a. Was an

29d. Date signed (Month, Day, Year)

performed? 1□ Yes 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

autonsy

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

200

-1	_		7		_			one of the second of the second
	2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street, f	actory, o	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
ı								e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number

D55658

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Arena, 100 East Carroll St., Salisbury, MD 21801

State Registrar 31. Date filed (Month, Day, Year) OCT 2 9 2007

29b. Signature and title of certifier



			1 - For State Registrar	State of Ma	aryland / Depa	artment of I rtificate of		Mental Hy	/giene 0 0 7	36111
	Physic	an	1. Decedent's Name (First, Midd	e, Last)				2. Date of D Month	eath Day Year	3. Time of Death
	/Medi		Nightsica:)			Oct.	18, 2007	ll: a. M
1	Examir	ner	4a. Facility Name (If not institutio				or Location of Dea	th	4c. County of Dea	
) 18	9	HCR Mano	r Care	e (In yrs. last birthday)		elphi If Under 24 Hrs	Q Data of P	Montgom	
и	FuneralDirector		225-58-5599	1 M 2 🔀 F	66 Yrs.	Months Days	Hours Min	. (Month, D		rthplace (State or Foreign ountry) ash D.C.
	D		Usual Residence of Decedent					July	29,1941 W	ash. D.C.
	rylan	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	a Ma	cto	MD Mont	gomery	Adelph	i				1 Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath v	Funeral Director	1801 Metze			207			U.S.A.	
	item item	nue	11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	o- 14. Race - Am Black, Whi	
36	irs af	by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☑ Divorced	If Yes Give		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
21215-0036	72 hours after death with the Maryland natural', or Itema 23a or 28a-f show Acal Examil ar must be notified at	ted	15. Deceder	nt's Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	
215	within 7 ene. than "n	ple	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	life.	kind of work done DO NOT use retire	during most of wo d)	rking		,
2	filled wit Hygien other the	Completed	12		Ba	nk Tell	er		privat	е
pu	be file d oth	Be (17. Father's Name (First, Middle,				18. Mother's Na	me (First, Middle	e, Maiden Sumame)	
yla	should but and Ment	ပ္	Bufford	Smith				Cor		
Maryland	C1 00 = 00		19a. Informant's Name/Relations						per, City or Town, State,	
	1 and 1ealth 1m 27 1her ti		Claudia Wee	eks/Daugnter		3 Rosin			le, VA.221	
Baltimore,	ges if of the	11.3	20a. Method of Disposition 1 Burial 2 Cremation	3 Pemoval from State	20b. Place of Dispo cemetery, crei	natory or other pla	(e) Oct	.24,07	20c. Location - City or	
Ħ,	it. Pa rtmer rtent njury		4 Donation 5 Other (S			incoln	cemeter	У	prenewoo	
Ba	permit. Departr Importe any injt		21. Signature of Funeral Service	B. Hunt	9	08 Kenn	edy St.	unt Fu N.W.Wa	neral Hom shington,	e DC 2001
P.O. Box 68760,	The law requires that the death certificate be executed by the attending physician and are been signed by the attending physician and be detached for use as the burial-transit	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a	A consequence of): a consequence of): a consequence of): of pregnancy 2 □Fetal death 3 □	Ectopic pregnancy		IA.	23d. Date of de Month	Interval Between Onset and Death Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between
	res that igned b be deta	by Pi	Part II. Other significant condition	ons contributing to death bu	it not resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
ğ	w require been sig should b	edt	1471	PERTENSION				1 🗆	Yes 2□No 3□P	robably 4 🛣 Unknown
of Vital Records,	The law requiste has been page 2 should	Completed						24a. Was		utopsy findings available completion of cause of
a		Ö	25. Was case referred to medica					1 ☐ Yes	No 1 □ Yes	3 2 □ No
>	Physician: r this certifica ral director, i	ToB	examiner? 1 ☐ Yes 34☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	t 3 DOA Oth		ath Check only	one. dence 6 □Other (Spe	
0	ding Ph		27. Manner of Death	28a. Date of Injur		28c. Injur			how injury occurred	(City)
Ö	Attending in death. ctor: After by the fune	atio	1 Natural 5 ☐ Pendin Pendin investig		Ye <i>ar)</i> Injury		k? Yes 2∐No			
Division	or Attenuation death	Certification:	3 ☐ Suicide 6 ☐ Could determ		ry - At home, farm, str	eet, factory, office		28f. Location (City or To	Street and Number or R	ural Route Number,
Ö	ospital or A hours after uneral Dire	Cer		g, oto	. (Орвону)			Oily of 10	wii, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier Check only one) Check only	g Physician: To the best of Examiner: On the basis of and manner stal	examination and/or inv	occurred at the tirvestigation, in my o	me, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	With To I		29b. Signature and title of certifie	0,		29c. Licens			29d. Date signed (Moni	•
•			,	du	Mo	_	0585	90	Oct. 24,2	.007
	(2)		30. Name and address of person Muttath Sur				Ave.#20	00 Rive	rdale,MD	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) OCT 2 6 2007	32. Registra	r's Signature				,	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:00A M Eleanor Mae Miller October 17,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months 1 □ M 2 🔀 F Days Director 90 2/12/1917 Maryland 577-01-3877 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Kensington Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3333 University Blvd. West 20895 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If Item 27 is marked of any Injury or other traumatic evenonce. Earnest M. Parker Emma Shepard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Roof/Daughter 12928 Allerton Lane Colesville, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State National Crematory 10/25/07 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 21. Signature of Funeral Service License 22. Name and Address of Facility National Funeral Home Th V Falls Church, VA 22042 7482 Lee Highway 23a. Part1. En of the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician CVA** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ! 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has rector, page 2 autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 1 Natural eral Director: After th filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and the of certifier. 29c. License number 29d. Date signed (Month, Day, Year) D60 October 18, 2007 10724 Little Patuxent Pkwy. Ste. 200 99. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Columbia, MD 21044 Shahab Bavani, 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 2 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death oct 26, **Physician** Day 20⁶7 8:55 AM Marshall Nashold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Caroline Home for Hospice Denton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 6 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. Dec 218-09-6250 84 Director Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Caroline Greensboro Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 21639 USA 26840 Whiteleysburg Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. All Dives 2 No If Ales, Give Year or Dates 1941 – 47 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. operations supervisor pharmaceutical permit. Pages 1 and 2 should be filed very pearment of Health and Mental Hygie Important: If item 27 is marked other? any Injury or other traumatic event, the any Injury or other traumatic event, the second that is the sec 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie M. Hooper Nashold George Harrison Nashold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton, MD 21601 Ronald J. Keller/ friend 8915 Discovery Terrace; 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐ Other (Specify) Eastern Shore Vet 10/31/07 | Hurlock, Maryland Cemeterv 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any Ir Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Carcinona disease or condition resulting in death) ne /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). requires that the death certificate be executed Due to (or as a consequence of): burialphysician a Box 68760 Physician/Medical SB IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy page ; certificate 1∐ Yes 2 No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 101 30/0-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ZaKi

31. Date filed (Month, Day, Year)

903

OCT 3 0 2007

AS 10+

Denton, MD

Market Street

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

hat initiated events esulting in death) Last	Due to (or as a conseq	uence of):				_	
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 □Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tot	bacco use contribute to the cause of death? es 2□ No 3□ Probably 4點Unknown		
				24a. Was a autops perform	sy prior to completion of cause of		
25. Was case referred to medical			26. Place of De	ath (Check only on	ne)		
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 ☐ Reside	ence 6 □Other (Specify)		
7. Manner of Death 1		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)		
29a. Certifier 1 ★Certifying Phy (Check only one) 2 ★ Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the curred at the time, d	cause(s) and manner as stated. date and place, and due to the cause(s)		
29b. Signature and title of certifier	1	2	29c. License number	2	d. Date signed (Month, Day, Year)		

00064029

Center Drive

October 16, 2007

20850

Rockville, MD

Registrar

State

filled in by 24 hours a

Medical

Brandon 31. Date filed (Month, Day, Year) 9901 Medical

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 6 2007

			State of Maryland / Department of Hotelstate of Maryland / Department of Hotelstate of Landstate			2001	36115							
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death							
	Physici /Medic		ROSE PERILSTEIN		Month OCTOBER	Day Year 23, 2007	7:10 A M							
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or		OCTOBER	4c. County of Death								
				VILLE		MONTGO								
	Funeral Director		5. Social Security Number 6. Sex 1	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign intry)							
			164-40-3915 87 Yrs. Usual Residence of Decedent		JULY ZU,	1920 POLA	עאַ							
	anylan show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits							
	he Ma	Directo	MARYLAND MONTGOMERY POTOMAC				1 X Yes 2 ☐ No							
	with I	ă	10e. Street and Number 10f. Zip Code 4 GOLDEN CREST COURT 20	0854	10	g. Citizen of What Cou USA								
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His	spanic Origin? (Spec	cify Yes or No-	14. Race - Amer	ican Indian,							
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Itams 23a or 28e-1 show aumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Specify Cubar	n, Mexican, Puerto F Specify:	lican, etc.)	Black, White								
Ş	hours tural',	d by	3 X Wildowed 4 Divorced Year or Dates:				WHITE							
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212	d with giene	Com	Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAK	KER		OWN HOM	E							
Maryland 21215-0036	be file tal Hy d oth	Be (18. Mother's Name		aiden Sumame)								
<u>₹</u>	d Men narke	T _o		GITEL "UNK										
Ma	s 1 and 2 should f Health and Men Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street all GAIL SINGER, DAUGHTER 4 GOLDEN CREST											
อ์	s 1 ar f Hea ftam other		20a. Method of Disposition 20b. Place of Disposition (Name of	Da		MAKY LAND Oc. Location - City or T	20854 Town, State							
Ē	Page nent o		1X Burial 2 ☐ Cremation 3 X Removal from State `4 ☐ Donation 5 ☐ Other (Specify) MONTEFIORE CEMETER		/2007 P	HILADELPHI	A, PA							
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any injury or other tra ance.		21. Signature of Funeral Service Lidensee 22. Name and Address	s of Facility	DIRECTI	ON. TNC								
	40 E 8 0	11 1	22. Name and Address of Facility DWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852											
	64 Feb.		3a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. nmediate Cause (Final isease or condition a. ACUTE MYOCAR DIAL INFARCT a. ACUTE MYOCAR DIAL INFARCT											
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7 sp	requires een sign hould be	d by	HYPERTENSION		1 ☐ Yes	No 3□ Pro	bably 4 Unknown							
2 / ecor		Completed			24a. Was an	24b. Were auto	opsy findings available							
- R	sician: The law certificate has b irector, page 2 s	Com			autopsy performe	ed? death?	ompletion of cause of 2 No							
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on	nding tth, r: Afte e fune	atlon	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work?	? ′es 2 □ No	JG. 15050115011011	injury cocomod								
Division	r Attal er des ractol by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	3f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,							
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	To the Hospital or Attanding Phys within 24 hours after death. To tha Funaral Diractor: After this completely filled in by the funeral dir	edical	29a. Certifier (Check only one) (Check only one) (Check only one)											
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	1		Doo!	18084	00	TUBER 2	3 2007							
			29b. Signature and title of certifier 29c. License	- 0- 0-	2/5:/:/	10 1,000	0							
			DI NESH PATEL M.D. G(Z) MONTROSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature	KI) RE	42VIC	5 more	1 89 5							
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State Registrar

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31. Date filed (Month, Day, Year)

OCT 2 6 2007

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Jerry Lee Quisenberry VOYEMBER CQ. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HORT GC. If Under 1 Year 8. Date of Birth (Month, Day, Year) OCT 26, 1949 7. Age (In yrs. last birthday, If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Virginia Director 222-30-1656 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 Tyes 2 No Director Troutville Virginia Botetourt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1433 Houston Mines Road 24175 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscaping Lawn Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Georgia Ann Smoot William B. Quisenberry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other trainonce. 1433 Houston Mines Rd., Troutville, VA 24175 Gary Quisenberry/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lawncroft Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Linwood, PA 21. Signa ure of Funeral Service Licensee P.A. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician omoteoldoile NKNOWN disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

/Medical Examiner The law requires that the death certificate be executed .O. Box 68760, Division or Vital Records, P. or Attending Physician; To the Hospital

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at

QUISENBERR Baltimore, Maryland

Known

physician the SB signed by the a s after death.

I Director: After this
d in by the funeral d within 24 hours a To the Funeral I

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State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YA Maryland Health Core System, Perry Point, MD 21902

31. Date filed (Month, Day, Year) NOV 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2 2007 1135 Roy Lee Rector November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F SEPT 9, 1946 Virginia 189-36-3752 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10h County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No **Funeral Director** E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 United States 156 Woolens Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic event, the Medical Examiner 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No ō Specify. Specify Completed by White 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 'Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be E. Lee Rector Wilma Haynes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 156 Woolens Road, Elkton, Maryland 21921 Lyn H. Rector/Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 9 20a. Method of Disposition Department of harmonic of harmonic life item any injury or other Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2007 Fair Hill, Maryland Sharps Cemetery Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Sig sture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSC Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consugrence of). Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð ASTROINTESTINAL Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page 2 s 1∐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D56811 BUW Spreet completed cause of death (Item 23a) (Type, Print) 30 Name and address of person w 106 54MAN AN HSMOK 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Leonard Franklin 22, 2007 8:30 A Reid, SrOctober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Tracy's Landing
If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. 5848 Solomons Island Road Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 79 10-05-1928 230-30-5674 Virginia Usual Residence of Decedent or 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Anne Arundel Tracy's Landing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or 2 5848 Solomons Island Road 20779 USA by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the alth and Mental Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify: white Specify. 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me College (1-4or 5+) supply sergeant US Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jaloler Franklin Reid Della Mae Pruitt ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 4550, Annapolis, MD 21403 Leonard F. Reid, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Friendship Cemetery 10-25-2007 Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Fungmal Service Licensee 21. Signature 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mentles disease or condition resulting in death) cancer /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed 1☐ Yes 2X No To the Hospital or Attending Physiclan: ours after death.

Interpretation of the servific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

8924 Chesapeake Avenue, North Beach, MD 20714 Robert Schlager, M.D.,

32. Registra Signature OCT 25 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Helen A. Rowland Oc t 28 11:30 P M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Homewood Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug 31 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F ~1915 92 MD 175 - 03 - 2482Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at MD Washington Williamsport 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 16505 Virginia Avenue 21795 USA 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or iter any Injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postmaster US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aaron S. Myers Leila Hartle ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Chaucer Way, Woodstock, MD 21163 Dennis Kershner nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 10/31/2007 Greencastle, PA 22. Name and Address of Facility Miller-Bowersox Funeral Home 21. Signature of Funeral Service Licensee 521 S. Washington St., Greencastle, PA 17225 Declorda 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deal Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a yearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) physician a the burial-Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 No the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the ngerlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation To the Hospital or Attending 1 Natural 2 ☐ Accident Injury al Director: An 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 30. Na

State
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31. Date filed (Month, Day,

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/Med Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Locat Frede			County of Deat	h			
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or 28a-f	Director	MD Frederi 10e. Street and Number		Freder	10f. Zip Code		10g. Citizen of What Country?					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturef", or items 23a or 28a-f show eny injury or other treumatic event, tre Madical Examination usiting at	y Funeral	1074 Redfield Co	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 41-4		21702 Was Decedent of Hispanic If Yes, specify Cuban, Mer	c Origin? (Specif xican, Puerto Ric	y Yes or No- an, etc.)	USA 14. Race - Ame Black, White Specify:	e, etc.			
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Dermi Depar impo		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Kathleen Rudy 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Septice Lice see MO1176 MO1176 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Poste 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Poste 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Date 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin Cousin 20c. Location - City or Town, State, Zip Cousin 20c. Location - City or Town, State, Zip Cousin Cousin 20c. Location - City or Town, State, Zip Cousin Cousin Cousin 20c. Location - City or Town, State, Zip Cousin Cousi										
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To the within 2 To the comple	Me	29b. Signature and title of certifier	Reilles	- MI	29c. License num	474	9 11	Date signed (Mon	th, Day, Year)			
241		30. Name/and address of person who	y MD 80	tem 23a) (Typ	Print) Hous	e Ave	e, D-1	FreDe	erick, my			
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State Registrar

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31. Date filed (Month, Day

D. Weld

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32. Registrar's Signature

Keswick

Road, Baltimore MD 21210

			For State Registrar		Maryland / D	epartmen Certificati			Mental Hy	giene Reg. No.	2007	36	123
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	Funeral		Social Security Number 6. 5		7. Age (In yrs. last birth	Months	1 Year Days	If Under 24 H	n. (Month, Da	th ay, Year)	9. Birth	place (State	
	Director		219-68-0406 Usual Residence of Decedent	- W 2831	84 Y	rs.			July	1, 19	923 Mar	ryland	
	ehow		10a. State 10b. County		10c. City, Town	or Location						10d. Inside C	ity Limits
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	eath v	Funeral	17610 Forest 6		C_LE dent Ever in U.S.	13 Was Doors	217		Specify Vec or No	. 1	4. Race - Amer	S.A.	
Maryland 21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-1 show al Examinar must be notified at	þ	1 Never Married 2 Married 3 ☑ Widowed 4 □ Divorced	Armed For 1 Yes If Yes, Giv Year or Da	ces? 2.1. No	If Yes, spec		Specify:	(Specify Yes or No arto Rican, etc.)		Black, White		
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		(shock, or heart failure. List only	rrest,		Approxima Interval Be Onset and	tween						
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	he death the atter	Physician/Med	1 Yes 2 No	4∐Pregna 9∐Unkno	ant at time of death wn	5 ☐ Other (sp	ecify)				WOTET	Day	l bai
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			1 -		eath (Check only	one)			
of	Physical di	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		atient 3 DO		4X Nursing	Home 5 ☐ Resi			ify)	
on	Attending Ir death. Sctor: After by the funer	ig.	Natural 5 ☐ Pending Accident investigatio	(Month	n, Day Year) Inj	ıry M	8c. Injury Work′ 1 □ Y	es 2 □No	200. 200000		00001100		
Division	in the	Certification:	3 Suicide 6 Could not be determined	28e. Place	of Injury - At home, farn g, etc. (Specify)	n, street, factory	r, office		28f. Location (City or To		Number or Ru	ral Route Nun	nber,
	Hospital 24 hours Funeral letely filled	edicai	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the miner: On the ba and mann	best of my knowledge, sis of examination and/ er stated.	daeth omnumed or investigation,	at the time in my opi	a date and sta nion, death oc	ta and dus to the curred at the time,	date and	and manner as place, and due	stated to the cause(s)
	To the within 2 To the complet		29b. Signature and title of certifier	7 1	1	!	License				signed (Month		
			I Monjan g	1800	h		128	365		10.	-28.0	フ	
SH	1-2		30. Name and address of person who MAW 2 AR. 9.	SHAP.	of death (Item 23a) (T 368 www. gistrar's Signature	ype, Print) 81vcu-	Ho	gentor	n M	02	1740	Uga	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 3 1 2	2007 32. B	gistrar's Signature	Special	,						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per verb., 8875 01/24/08/hb

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Month Year Charles Clifton Smith, Jr. October 292007 0945 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital at Easton Laston Talbot | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 18 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8 Maryland **Funeral** Months 1X M 2□ F 214-70-5938 Director 1958 Usual Residence of Decedent Show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits sa or 28a-f show t be notified at 1 X Yes 2 ☐ No Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Maple Ave. #3A 21639 23a U.S.A. **Examiner must** or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) graphic artist sign manufacturing 12 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F t and 2 should be Health and Ment Charles C. Smith, Sr. Pauline Harrington Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline H. Smith/ mother 207 Maple Ave Apt.3; Greensboro, MD 21639 other permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Cn 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 10/29/07 Chester, Maryland 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD 2163 shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760 physician Physician/Medical attending IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) Ö the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ The law requires combasis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1∐ Yes 2 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature 29c. License number and fittle o 29d. Date signed (Month, Day, Year) 1468, M.D.D & Ø656 SE 29, 200-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Austin C T Date filed (Month, Day, Year)

Tagbo,

1 2007

219 S. Washington St. Easton, MD 21601

MD: 219 S P. Registrar's Signature

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U / -	00211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Robert Gottwals Shockley	State of Maryland / Department of Health
,	Otate of Maryland / Department of Fleatin

2007	36	12	1
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		1- For State Ce	rtificate o	f Death		Re	g. No.	11 3012
Physicia Medical Exami		Decedent's Name (First, Middle,Last)	У			2. Date of Death Month October 24	h Day Year	3. Time of Death 1525 hrs
		4a. Facility Name (if not institution, give street and number) 324 Railroad Avenue		4b. City, Town, o Goldsboro	r Location of Deat		4c. County of Deat Caroline	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 220–28–1669 1XM 2F 74		If Under 1 Ye Months Da		_	h(MM/DD/YYYY) 9. Bi 9 1933 C	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Directo	Usual Residence of Decedent 10a. State 10b. County Maryland Caroline G 10c. City Maryland Caroline 324 Railroad Ave. 11. Marital Status 1 Never Married 1 Never Married 2 Married 12. Was Decedent Ever in Uarried Forces? 1X Yes 2 No 1Yes 2 No 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last) HOWard R. Shockley 19a. Informant's Name/Relationship (Type, Print) April Crampton/ daughter 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	19b. Mailin 30 N Place of Disposerematory or ot	as Decedent of H Yes, specify Cubs Yes 2 X N nt's Usual Occup- nost of working life Duntant Grand Address (Streen Streen	ation (Give kind of e. DO NOT use re /truck 18.Mother's Nam Dorot et and Number or Street emetery,	work done tired) work done tired) driver e (First, Middle, M hy G.Go Rural Route Num ; Magno	Og. Citizen of What Cou USA 14. Race - Ame White, etc. Specify: Wh 16b. Kind of Business Grain i Maiden Surname) Ottwals ber, City or Town, State Clia, DE 20c. Location - City of	10d. Inside City Limits 1 X Yes 2 No untry? rican Indian, Black, ite //industry ndustry Shockley ie, Zip Code) 19962 or Town, State
Physician /Medical xaminer	cal Examiner	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED Other Specify: GT Attence Circles Due to (or as a consequence of the death of the dea	n. Do not enter to vascular Disor):	Name and Address Leegle Leon 1 Leegle Leegle Leon 1	s of Facility		Greensbo n Funeral n MD 216 est, shock, or heart	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed by Physiciar	Part II. Other significant conditions 23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de 9 Unknown contributing to death but not a	2 Feeath 5 Of	ther (Specify) underlying cause	Ectopic pregn given in Part I.	23e. Did to 1 Yes 24a. Was a autop: perfor 1 Yes	an 24b. Were a prior to med? death?	Day Year o the cause of death? obably 4 Unknown utopsy findings available completion of cause of
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Medical Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 1 Natural 5 Pending	dge, death occur	t 3 DOA Injury 28c. Inj 1 to 1 to 1 to 1 to 1 to 1 to 1 to 1 to	Other4 Nursi ury at Work? Yes 2 No building, etc.	28d. Describe h	tate) e(s) and manner as sta	tural Route Number, City
To with the Tro	Мес	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Iten Patricia Aronica-Pollak MD. Assistant Medical	رسي n 23a)	29c. Licen			29d. Date signed (M. October 25, 200	onth, Day, Year)
St. Regist		31. Date filed (Month, Day, Year) OCT 3 0.2007			,,	,		
DHMH 17 Rev 1/20		OCME	ORIGINA	L				

DHMH 17 Rev 1/2001 OCME 2006 AS 6+

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Floyd B. Thayer November /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL BALTIMORE CITY BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X M 2 ☐ F Hours Director 234-83-0377 May 15,1925West Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location Thank Hampstead Director Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 17912 Marshall Mill Road 21074 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status PROIS 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. Š 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction the Welder 8 and Mental Hygidis marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evone. Steve Thayer ပ္ Lucy Gellispie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 17912Marshall Mill Road Hampstead, Maryland Connie Cover/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Newville Cemetery 11-05-07 4 Donation 5 Dother (Specify) Newville, WestVirginia 21. Signature of Funeral Service Licensee michael Marzullo Funeral Chapel, P.A 1. marghell 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a ACUTE Physician INTRA CEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner HYPERTENSION Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed aftending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ARTERY DISEASE CORONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HS.ART DISEASE ISCHEMIC 24a. Was an autopsy ABDOMINAL ANEURYSM Be

Hospital or Attending Physician: 24 hours a within 2 To the I

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 patient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 2, 2007 RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

14:29 Rm

Virginia

1X Yes 2 □ No

10d. Inside City Limits

Approximate Interval Between Onset and Death

7 days

years

Year

Birthplace (State or Foreign Country)

2067

14. Race - American Indian,

Black, White, etc.

Specify: White

23d. Date of delivery

Month

4c. County of Death

3 State Registrar

Certification: To

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signature 31. Date filed (Month, Day, Year)

NOV 0 9 2007

SINAL HOSPITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 = State of Maryland / Department of Health and Mental Hygiene
Registra/MEND#SperrFH10/29/07, BWW, Moco

Certificate of Death

Red. No. 1. Decedent's Name (First, Middle, Last)
Taqua Ollie 2. Date of Death Trescott Dav Month **Physician** A^{M} Tagua Ollie Trescott 2007 7:30 October 22, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Sacred Heart Home Hyattsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day Year)
Aug. 21 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 93 Director 579-09-8379 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 X Yes 2 No Director DC N/A Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or i up yor other traumatic event, the Medical Examiner must be nuy or other traumatic event, the Medical Examiner must be n 4300 South Dakota Ave., N.E. 20017 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 X Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Food&Drug Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ۵ Henry Fuqua Nellie Otey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is any injury or other traum Myrtle T. Banks / Step Daughter 1925 Varnum St., N.E. Washington, D.C. 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. Oct. 29, 2007 Brentwood, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee Endre 7400 Georgia Ave., N.W. Washington, D.C. 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia 2 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed and resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an nas autopsy performe certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: Will Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No ပ 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after

Box 68760 Ö Δ. or Vital Records, Division Hospital or Attending

within 24 hours a Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

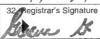
State Registrar

CHOWDHURY, MD; NURUL 31. Date filed (Month, Day, Year)

OCT 2 6 2007

Chow day, mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

DINO DR.; BURTONSVILLE, MD 20866

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Montal Hyd

			For State Registrar	State of Mai		Certificat			F	Reg. No.	2007	36128	3
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	edic mine		Sigrid Maria 4a. Facility Name (If not institution, give		VOII	Bremen 4b. City.		omas or Location of Death	October		2007 County of Death	10:09 PM	_
EXa	HILIIK	ar T	9801 Sotweed Dri	ŕ			toma				lontgomer	·v	
Fune	rai		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	hday) If Under			8. Date of Birtl	h		lace (State or Foreign	_
Direc	tor		117-30-9833	□ M 2 X F	75	Yrs.			Nov. 11			tonia	
and		- H	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. inside City Limits	_
Maryl -f sho	2	to	Maryland Monte	omerv	Po	tomac						1 ☐ Yes 2 No	
h the		Director	10e. Street and Number	,omer j	10	10f. Zip	Code			10g. Citi	zen of What Cour	ntry?	
th wit	165	ョ	9801 Sotweed Dri	.ve			2085	4		Un	ited Sta	ites	
er dea	5	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Deced	ent of l	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- to Rican, etc.)		 Race - Americ Black, White, 		
and 21215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. ntal Hygiene. of other than "natural", or items 23a or 28a-f show shoot the Madical Evanings must be notified at	Yall	by Fi	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:)	1 □ Yes	2 ⊠ No	Specify:			Specify: Whi	to	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. Tris marked other than "natural", or transpare sevent the Modical Exam	7	ted	15. Decedent's Ed	lucation	16a.	Decedent's Usua	al Occu	pation		16b. Ki	nd of Business/In		-
215 thin 7 ie.		Completed	(Specify only highest gra	College (1-4or 5+)	life. DO NOT us Author	se retire	during most of wor riter	King				
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Maryland 2' 12 should be filed w 12 should be filed w n and Mental Hygie 1 is marked other t		ှ	Karl William 19a. Informant's Name/Relationship (von Bremen Type, Print)	19b.	Mailing Address	(Street	Erika and Number or Ru			tohlkors		-
and 2 sealth ar			Richard King Tho		. [•	Drive, Po				•	
os 1 and of Health item 27	5	18	20a. Method of Disposition			Disposition (Nar. y, crematory or o	ne of ther pla	ice)	Date		cation - City or To		_
Pages Pages nent of I			1 ☐ Burial 2 ☑Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					tory 10/2	7/2007	Bre	entwood,	Maryland	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke	once.		21. Signature of Funeral Service Licer						imple Tr			-	
u 805	5 5		ensy					ille Pike			, Maryla		
			23a. Part1. Enter the disease, or com shock, or heart failure ust only	plications that caused to one cause on each line	he death. Do n	ot enter the mod	e of dyi	ng, such as cardiad	c or respiratory ar	rest,		Approximate Interval Between Onset and Death	
Physici /Medic		1	Immediate Cause (Final disease or condition resulting in death)	a Ovarian (18 months	
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Or Vita Physician: rthis certification and director and d		Be	25. Was case referred to medical examiner?	Hospital:			Lou		ath (Check only o	ne)			
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10		1	30. Name and address of person who	completed cause of do	ath (Item 27a)	-	D54	3/8		10/	23/2007		
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Amend Items 23aPtI,28b,d per me, 9873, 11/09/07dhb

Reg. No. 2007 2,29d Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 10/21/2007 **Physician** Catherine Irene VanMeter 0138-M 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | August 2, 1933 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 216-36-6417 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits West! 28a-f show Examiner must be notified at Berkeley 1 Yes 2 No Falling Waters Directo Virginia the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 357 Narrow Lane 25419 United States items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hyglene. Item 27 is marked other than other traumatic event, the M Certified Nursing Assistant Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert H. Dill Clara Alcinda Dwyer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gail Hedges / Daughter 357 Narrow Lane, Falling Wathers, WV 25419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunshine, Maryland Mt. Carmel Cemetery 24, 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Reeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD:21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hip Fracture with Complications **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Fielar or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No 28a. Date of Injury
(Month, Day Year)

C 7 12, 3 TO 7 Unknown 28d. Describe how injury occurred Subject fell. 28c. Injury at Work? 27. Manner of Death After Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No 2 Accident i Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Ficility living within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causers and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier oct 22, 2007 2007 -1062

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State Registrar i 96/161ch tem Rd begariour, 145)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 0 9 2007

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12501 rior 200-/Medical on Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner NUE Sign ama Margar ayen If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex-**Funeral** Months Days Hours 1 M 2 F 81 Director 12, 1926 Marvland 226-22-5034 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, or Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 TYPS 2 □ No Baltimore Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 United States 3939 Pennhurst Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Specify: White 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Š 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Various Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winston Robert Kiker Marion Edith Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frances Green Court, North Potomac, MD 20852 Julie Maizels-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10-26-2007 Brentwood, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 21. Signature of Funeral Serv 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physician end I for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 500 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Manner of Death Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760 ours after death. eral Director: After this certificete hes been signed by the e filled in by the funeral director, page 2 should be deteched or Attending Physician: within 24 hours a
To the Funeral I
completely filled To the Hospital

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifies

29c. License number

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed TEM

State Registrar

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4 Homicide

29a. Certifier (Check only one)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Trederick 30 M. Sr. October 2007 22 Carl /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner altimore The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 □ F 67 Director 215-36-4574 06/29/1940 Wash. DCUsual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2011 Timberneck Drive 20736 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married "natural", or 1 ☐ Yes 2 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber Plumbing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any Injury or other traumatic evone. Norval Wilson Mary Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings, MD 20736 2011 Timberneck Dr. <u> Eileen Wilson - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens 10/26/2007 Dunkirk, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee Lisa M. Mount 8125 Southern MD Blvd., Owings, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe Sepsis Day. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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Records, Division or Vital

Box 68760.

P.O.

altimore, Maryland 21215-0036

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29b. Signature and title of pertifier

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

as Hopkias Hospital, 600 North Wolfe Street, Battomore, Magland 21287

32. Registra Signature 31. Date filed (Month, Day, Year) 2007 26

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A Constant of Science (Speed) 21. Signary for the Second Truncal Home 22. In Signary for the Second Truncal Home 127 South Main Street, North East, Maryland21901 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speed, or heart failure. Little with one cause on each line. Physician Medical Examiner 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speed, or heart failure. Little with one cause on each line. Physician Medical Examiner 24. Do not enter the mode of dying, such as cardiac or respiratory arrest, speed, or heart failure. Little with one cause on each line. 25. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speed, or heart failure. Little with one cause on the each line. 25. Due to (or as a consequence of): 26. Lives counter purpose. Little with one cause of death? Part I in the past 12 months? 26. Lives counter purpose. Little with one cause of death? 27. Due to (or as a consequence of): 28. Was decedent pregnant of time of death and time of death and time of death and time of death and time of death. Science of death? Part I in the past 12 months? 26. Unknown 27. Authors of Death (The example) and time of death and time of death and time of death and time of death and time of death and time of death and time of death and time of death and time of death? 28. Was case referred to medical and time of death but not resulting in the undenying cause given in Part I. 28. Place of delivery 29. Due to (or as a consequence of): 29	ב ב	ges 1 It of H If iter						e) Octob	<u> </u>		-	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUI-CHIH H5U M.D. 223 W. Moin St. E/Kfort MD 2/92/ State Registrar OCT 2 9 2007 Registrar's Signature OCT 2 9 2007				I Ami cea Ne	MD		Do	4823		10	1261	07
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		7~11/A		30. Name and address of person who completed TUI - $CHIH$ $H5IJ$ $M.Z$	cause of death (Item 2	3a) (Type,	Print) Sin St.	E/ttor	Z MD	21	921	
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			. 101	partment of Health and Mer ertificate of Death	ntal Hygiene Reg. No. 2007	36133
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death
Ø.,	/Medio	cal	ORIMOLD M. AKWARA 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	1134 M
	Examir	ıer	Bowie Health Center	Bower	Prince 6	ecles
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 F 73 Yrs.	Months Days Hours Min.	(Month, Day, Year) Country	ce (State or Foreign y) NIGERIA
en	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I		, moson,	d. Inside City Limits
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	a or 28a st be not	Funeral Director	10e. Street and Number 1905 ALTHEA LANE	10f. Zip Code 20716	10g. Citizen of What Country USA	y?
5-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show kdical Examiner must be notifled at	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric		
2-0	"natur	leted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Indu	stry
717	d within 72 hogiene. giene. ir than "natu the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	RADER	PRIVATE	
yland	be filed ntal Hygid	Be	17. Father's Name (First, Middle, Lest) EMBIE APALE	18. Mother's Name (Fi	irst, Middle, Maiden Surname) OI	
Maryi	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.	오	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Rural R ALTHEA LANE BOWIE,	oute Number, City or Town, State, Zip C	Code)
saitimore,	Pages 1 ar ent of Hea nt: If Item 2 y or other		20a. Method of Disposition 20b. Place of Disposition 1 1 1 1 1 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FAMILY	ematory or other place)		
Dali	permit. F Departm Importar any Injur		21. Signature of Funeral Service Licensee		B. JENKINS FUNERAL	HOME
i			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate nterval Between Onset and Death
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/	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
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ds, r.	The law requires that the ate has been signed by the page 2 should be detache	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the	
necoras,	he law req s has beer ge 2 shou	Completed			autopsy prior to comp performed? prior to comp	sy findings available pletion of cause of
VII	sician: The law certificate has b irector, page 2 s	Be Co	25. Was case referred to medical exampler?	26. Place of Death (C		No No
> 5	Physic this ceral dire	은	1 Yes 2 No Hospital: 1 Inpatient 2 No Prime 27. Manna of Death 28a. Date of Injury 28b. Time		5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred	
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	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f.	Location (Street and Number or Rural I City or Town, Stete)	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred	at the time, date and place, and due to t	the cause(s)
	vithi To t	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Da	ay, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	Novembe	13,2001
			29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type 5 4 4 5 4 5 5 4 5 5 6 5 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7	Prine Cr	weel Maylas	d
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State of Maryland / Department of Health and Mental Hygiene 000 / 36 1 3 4

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of L		, ,	gierfe	'	
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Dea		ear	3. Time of Death
	/Medic	Joseph H. Althori					1 1 -07 - 2	2007		9:20 Р м	
	Examir							4c. County of			
			9906 Magledt Rd	17.	- A blade de N	Parkvil		Ta a same	Baltimo		
	Funeral Director		220 30 3210 -	M 2□F	e (In yrs. last birthday) 71 Yrs.	tf Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 09-08-1	1936 N	Countary	lace (State or Foreign try) Land
	anyland show	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2X No
	he M	Director	Maryland Baltimor	e	Parkvill						
	with t	Dir				10f. Zip Code		1	l 0g. Citizen of Wh	at Cour	itry?
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other traumatic event, the Medical Examination at once.	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	10	Was Decedent of Hi f Yes, specify Cuba l □ Yes 2X No	Specify:	Rican, etc.)	Black, Specify:	White,	etc.
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Ž	should nd Me mark matic	2	John Henry Althoff 19a. Informant's Name/Relationship (Ty		19h Mailin	g Address (Street a			r City or Town St	ate Zin	Codel
	nd 2 s lith ar 27 is r trau			Daughter)		ottinghar				110, <i>Lip</i>	0000)
ē,	s 1 ar f Hea item other		20a. Method of Disposition		20b. Place of Dispo				20c. Location - Ci	ty or To	wn, State
Ë	Page: ent o nt: If ry or		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	Gardens o			0-2007	Baltimor	e. N	Marvland
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			23a. Part1. Enter the disease, or compl	cations that caused		705 Be1a:)	Approximate
8	Pnysician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition									Interval Between Onset and Death
			disease or condition resulting in death)		a consequence of):	inces				-	4 months
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	e Hospital or 24 hours afte e Funerel Dir letely filled in		29a. Certifier 1 Certifying Phys	ician: To the best of	of my knowledge, death	occurred at the tim	e date and place	and due to the or	alica/s) and mana	er ac c*	ated
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	Medical	(Check only 2 Medical Examination)	er: On the basis of and manner sta	examination and/or inv	estigation, in my op	pinion, death occurr	red at the time, da	ate and place, and	due to	the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	101	7	29c. License	number		9d. Date signed (A		
			> Clh Clial	full	110	024	1356		Novemb	es c	1 2007
(7		30. Name and address of person who co	npleted cause of de	eath (Item 23a) (Type, I	Print)	~	01 0	has 01		1
_	<i>b</i>		William Waterfield	d 9103	Franklin	Square	Drive	stea	10 Bal	inno	100 MD2123
	Sta	-	31. Date filed (Month, Day, Year) NOV 1 3 200		r's Signature	all of	•				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 873 11-13-07 vt. State of Maryland Pepartment of Health and Mental Hygiene 0 77 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year PHYLLIS **KROLL** 12:15A M ARNOW NOVEMBER 10 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 □ F 168-20-8706 80 10/16/1927 PA Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ☐ No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10500 ROCKVILLE PIKE #306 20852 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏ Yes 2 🏋 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER SOCTAL WORK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL ARNOW **KROLL** DOROTHY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY ARNOW / BROTHER 31 MARSHALL DRIVE - EDISON, NEW JERSEY 08817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SHARON SPRINGFIELD. PA. 11/11/2007 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Chy Wall Approximate Interval Between Onset and Death 23a. Part t, Inter ne disease, ir o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 □ No 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tyes Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner physician and the burial-transit Division or Vital Records, P.O. Box 68760) as nse signed by the has funeral After within 24 hours after death.

To the Funeral Director: At completely filled in hour.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

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29a. Certifier

29b. Signatur

(Check only one)

MD

Funeral

Director

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 is
any injury or other trau

Physician

Maryland 21215-0036

State Registrar

Gabriel Peter Pushkas 3 200° 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suburban Hospital

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1vr+le Bur 1:50 PM 2007 NOV 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 216-34-0259 Min. 1 □ M 2 X F 70 Director 12/23/1936 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show ant; If item 27 Is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No MD Halethorpe Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21227 2730 Alderwood Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Estella Brown George Brown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any injury or other trau 801 Lynnvue Road, Linthicum, MD 21090 Anna Bryant / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Removal from State Meadowridge Memorial Park 11/10/2007 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01378 23 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 hours Inhalational Injury STATE OF THE PARTY /Medical Due to (or as a consequence of): Examiner Anoxic brain injury

Due to (or as a consequence of): 2 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【CUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an page 2 s certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2∐ No 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Injury 1 Natural 5 Pending investigation Viction ours after death. 1 ☐ Yes 2 MNo 07 0114 09 6 2 Accident 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 ☐ Homicide it ale Thorpe, Alderwood 2730 within 24 hours a 29a. Certifier 1X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 1/2001 NE 23113

of Maryland Hedical Center

with

University 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cristin Mount, MD

Year)

31. Date filed (Month, Day, NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1500KER 09 NOV 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL Columbia Min. ItOSPITA(HOWARD Count 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 □ M 2 🛛 F **Director** West Virginia 216-34-4621 Aug. 13 1935 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9425 Kilimanjaro Road 21045 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Sercuity Elementary/Secondary (0-12) College (1-4or 5+) Disability Clerk Administration 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 Is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond W. Kirk Myrtle Newhouse ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Booker (Husband) 9425 Kilimanjaro Road Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place Columbia Memorial 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-14-2007 Clarksville, MD 4 Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Homes, Inc. MO1050 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 DEctopic pregnancy for Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 2 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform certificate 1 Yes 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA poatient this filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? : After ! 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of cer 29c. License number who completed cause of death (Item 23a) (Type, Print)

MD 10700 CHANGO INVE 200 COUMB A MO21044

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

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Division or Vital Records, P.O. Box 68760,

		For State		State of	f Maryl		oartment (e <i>rtificate</i>		alth and M		_	711111	36	38
Physici	an		ne (First, Middle, La		CVT		rimodic	01 00	Julii	2. Date of De	Reg. No.		3. Time of	
/Medic	al		LOUIS B				4b. City. To	wn. or La	ocation of Death	Novem	sev 1	2 200 7 County of Dea		JAM
Examin	er	Union	Memoria	l Hosp	ital		Bal	tim	ore					
Funeral Director		5. Social Security 1 219-16-	-7744	Sex M 2□F	7. Age (In	yrs. last birthda 80 Yrs.			f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug.	ay, Year)	C	thplace (State of buntry) Ltimore, N	
yland Iow at		Usual Residence o	10b. County			. City, Town or I							10d. Inside Cit	ty Limits
he Mar 28a-f sh otified	Director	MD	Baltimore			Nottingh					10.00		1 □ Yes	2 ⊠ No
th with i		10e. Street and Nu 4 Willow 1	Path Court				10f. Zip Co 2123					izen of What Co	ountry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Man 3 □ Widowed	rried 2 Married 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces?		B. Was Deceder If Yes, specify 1 ☐ Yes 2		anic Origin? (Spi Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whi Specify: Whi	e, etc.	
n 72 ho "natur edical	Completed		15. Decedent's E	ducation ade completed)	***	16a. Dec	edent's Usual (Occupation done duri	on ing most of work	ing	Ī	ind of Business	Industry	
ed withii /giene. er than t, the M	Comp	Elementary/Second		College (1	-4or 5+)		ionary En	ginæ	r			e Food		
ud be file Tental Hy rked oth Isc event	To Be (17. Father's Name Louis Bio	e (First, Middle, Last edronski)				18	B. Mother's Name Frances I		, Maiden	Surname)		
and 2 shousalth and N		_	Name/Relationship (4 Will	low Path (Court	Number or Run Nottingh	al Route Numb em, Mary	er, City o and 2	or Town, State, 21236	Zip Code)	
Pages 1 ment of He ant: If Iten lury or oth			sposition Cremation 3 5 Other (Special		State P	b. Place of Disp cemetery, cr arkwood (<u>-</u>		11–15-		Park	ville, M	aryland	
permit. Depart Import any inj	i	21. Signature of F	uneral Service Lice	spe Jan	Total	6	22. Name an g 3 800 Harf o	Waltes I ord Ro	Mineral d d. Parkvil	napel & C	remat vland	ion Serv. 21234	ices Park	ville
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cuted Id ransit	Examiner	Sequentially list out any, leading to in cause. Enter Under Cause (Disease of that initiated events)	mmediate erlying r injury	C.	or as a com	sequence on.								
cate be executed physician and the burial-transit	dical Ex	resulting in death)	Last	Due to (or as a con	sequence of):								
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e la has	Completed									24a. Was auto perfo 1∏ Yes		death?	utopsy findings a completion of ca 2 \(\text{No}	available ause of
ysiciar is certif director	To Be	25. Was case refe examiner? 1 ☐ Yes 2 ☑	/	Hospital: 1 델i	npatient :	2 ☐ ER/Outpati	ent 3 DOA	Other:	 Place of Death Vursing Ho 			6 □Other (Spe	ecify)	
ding Ph		27. Manner of Dea 1 ☑ Natural	5 Pending	,	of Injury th, Day Yea	r) 28b. Time Injury	of 28c	: Injury at Work?		28d. Describe			 ,	
To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	e 28e. Place	of injury - Ang, etc. (Sp	At home, farm, s recify)				28f. Location (City or To	Street an wn, State	nd Number or Fi e)	ural Route Num	ber,
e Hospit 24 hour e Funera letely fill	Medical (29a. Certifier (Check only one)	1 ☐ Certifying Pl 2 ☐ Medical Exa	niner: On the ba	best of my asis of exar ner stated.	knowledge, de nination and/or	ath occurred at investigation, in	the time, n my opin	date and place, iioп, death occur	and due to the red at the time	cause(s) and manner a d place, and du	s stated. e to the cause(s	5)
To th To th comp	Me	29b. Signature and	d title of certifier _	Tomic	, H	D	29c. L	icense ni 243	umber 38946	,		te signed (Mon	th, Day, Year)	07
15+1		DRA	ress of person who	completed caus	e of death (Item 23a) (Type	Print)	ME	MORI	AL H	USF	PITAL	MD	
Sta Registr		31. Date filed (Mor	nth, Day, Year) NOV 1 3		istrar's S		halls		,					
								-						

William Harry Burkheimer

2007 36		3 9
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		1- For State Certificate of Dea	th	R	eg. No.	0010			
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) William Harry Burkheimer 2. Date of Death Month Day Year November 10, 2007							
1		4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death		4c. County of De	eath			
		The state of the s	re de Grace der 1 Year If Under 24Hr:	Dieth-Less (State or					
Funera Directo		5. Social Security Number 219-40-7342 6. Sex 12 F 65 Yrs. [If United Security Number 6. Sex 12 F 65 Yrs.]	rth(MM/DD/YYYY) 9. , 1942	oreign Maryland Country)					
*		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
daryland 28a-f show any	to	Maryland Harford County Aberdeen				1 Yes 2 X No			
the Mary	Director		ip Code)01		Og. Citizen of What C United Sta				
15-0036 filed within 72 hours after death with the Maryland I Hygiene.	Funeral Director	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	dent of Hispanic Origin? (S cify Cuban, Mexican, Puert		White, et	ŀ			
		3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:		Specify: Wh				
hours	ted		al Occupation (Give kind of orking life. DO NOT use re		16b. Kind of Busine	ess/Industry			
036 ithin 72 hours afi me. refinal "matural"	Completed	12 N/A Farmer			Farming	Ð.			
D 21215-0036 should be filed within 7 and Mental Hygiene.	Be Co		18.Mother's Nam Marie Al	•	Maiden Surname)				
MD 21 Id 2 should to the and Mer m 27 is man	ے اے	19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret Burkheimer (Wife) 617 Gilk	ss (Street and Number or pert Road Abe	erdeen,	Maryland 2	21001			
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important. If item 27 is n	omer ita	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Evans Funeral	e))	Date 114107	20c. Location - Cit	ty or Town, State ill, Maryland			
Baltir permit. I Departm Importa	mlary o	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service Service Forest Hill, Maryland							
Physicia		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart							
/Medica xamine	_	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):				Between Onset and Death			
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	n/Medical	UNPENDED AMENDED							
3760, ificate be g physicial	J/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	h 3 Ectopic pregr	nancy	23d. Date of de Month	livery Day Year			
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate by redath.	Physician	past 12 months? 4 Pregnant at time of death 5 Other (Sc				22,			
b. B.	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did	tobacco use contribu	te to the cause of death?			
, P.O. res that the signed by	p p			1 Y	es 2 🗸 No 3	Probably 4 Unknown			
ords w requi	Completed by			24a. Was	psy prio	re autopsy findings available or to completion of cause of			
tal Reco	om (performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No							
cian:	Be (25. Was case referred to medical examiner?	26.Place of Death (Check		1				
of Vi Physic er this	2 B	1 Ves 2 No Inpatient 2 En/Outpatient 3	DOA Nurs 28c. Injury at Work?	ing Home 5	Residence 6 0	Other:			
on of ending Pl sath. or: After	ition: To	1 Natural 5 Pending Nov 10, 2007 Pending 1741 hrs	1 Yes 2 No		auto collision				
E a ga di	Certification:	2 ✓ Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	ory, office building, etc.			or Rural Route Number, City oad, Aberdeen, MD			
	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea								
To To	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
		Marine Michael O.C.M.E. November 11, 2007							
10		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn S	street, Baltimore, MD	21201					
Rea	State	31. Date filed (Month (No.), (Year) 2007 32. Registrar's Signature	,						

DHMH 17 Rev 1/2001

			1- For State of Maryland / Departs Registrar Certif	ment of Hea ficate of De		ental Hygie Reg.	700	7 36141
	Dhuaisi		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
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Ž.	Examir	er		b. City, Town, or Loc			4c. County of I	
4			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If		8. Date of Birth		NA Birthplace (State or Foreign
ь	Funeral Director				lours Min.	(Month, Day, Ye 12–20–1	ear)	Country) Md.
.60	P .		Usual Residence of Decedent				1020	
	arylar show	ř	10a. State 10b. County 10c. City, Town or Location	on				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M 28a-f notifie	Director	Md. NA Baltimo	ore 10f. Zip Code		100	Citizen of Wha	Λ
	ya or	õ	1400 E. Madison St. Apt. 512	21205		Tog.	USA	t Country?
	172 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispa	inic Origin? (Spec	cify Yes or No-	14. Race - /	American Indian,
Q	after or ite mine		1 Never Married 2 Married 1 Wes 2 No	es, specify Cuban', M Yes 3√ No <i>Si</i>	viexican, Puerto F pec <i>ify:</i>	ilican, etc.)		White, etc.
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7	n 72 l ı "nat edlca	Completed	(Specify only highest grade completed) (Give kind	t's Usual Occupatior of of work done durin NOT use retired)	n ng most of workin	g 16t	b. Kind of Busin	ess/Industry
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פ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)		Mother's Name	(First, Middle, Mai	iden Surname)	
yland	uld by Ments arked	ToE	Early Brooks		Minnie		Faulkne	er
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n D	Dep Impo			Ol E. Nor	Mai	rch F.H. , Baltimo	East ore, Md.	. 21202
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4	ured ansit	E .	Cause (Disease or injury					
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õ	ertifica ing ph e as t		IF FEMALE:					
Z D	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant 12b. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ect	topic pregnancy			23d. Date o Month	
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Ĕ	The late ha	mo:	RSCUP			autopsy performed 1 Yes 2 🛣	dea dea	r to completion of cause of th? Yes 2 x No
	ctor, I	Be	25. Was case referred to medical examiner?	26.	. Place of Death	(Check only one)		75.
5	hysic this co	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3		Nursing Hom	ne 5 ☐ Residenc	e 6 □Other (Specify)
	ling P After funera	ion:	27. Manner of Death 1 ⚠ Natural 5 Pending (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?		8d. Describe how i	injury occurred	
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2	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	radioly, dilloc		City or Town, S		r ridiai riodie Nambei,
1	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only (Ch	curred at the time, of	date and place, a on, death occurre	nd due to the caused at the time, date	se(s) and manne and place, and	er as stated.
1	o the ithin 2 or the or	Med	one) and manner stated.					Month, Day, Year)
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	\		30. Name and address of person who completed cause of death (Item 23a) (Type. Prin	it)	2016		11121	J /-
	\		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Lands 12 (205 and 12 and 12 and 13 and 13 and 13 and 13 and 14 and 14 and 15	It Sute	· 4/202	7 cms an	my	21204
	Sta	te	31. Date filed (Month, Day, Year) 32. Highstrar's Signature	ومحمد				
	Registr	ar	MAN TO TOOL TO SERVE IN THE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 8, 2007 12:20 PM Lawrence George Bockstie Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. ocial Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 12XM 2□F Hours Min Director 217-20-0927 82 Jan. 8, 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 🛣 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 21015 1702 Jennings Drive USA Funeral ed other than "natural", or Items event, the Medical Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify þ Specify: be filed within 72 hours 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Research Chemist Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental ပ Pages 1 and 2 should Lawrence George Bockstie Sr. Hilda Marie Buettner of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresita A. Bockstie / Wife 1702 Jennings Drive, Bel Air, MD 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdn 11-12-07 Fallston, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Curs Slige 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA ZULTELU E /Medical Due to (or as a consequence of): Examiner BRONCHIECTESIS 10465 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? Yes 2 180 Vital 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 punpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA Division or Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number D0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ason Birnbaum, M. D. 500 Upper Chesapeake Dr. Bel AGr, M 32 Alegistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

November

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DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of Mary		artment of <i>rtificate o</i>		l Mental Hy	/giene Reg. No		36143
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			Usual Residence of Decedent		70 Yrs.			October	<u> </u>	937 Mar	yland
	aryłan ehow	_	10a. State 10b. County Maryland N/A	10	Oc. City, Town or Lo					1	Od. Inside City Limits
	the M	ecto	Maryland N/A 10e. Street and Number		Baltin	10f. Zip Code			10= Ca	inan of Milat Court	1X Yes 2 □ No
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36	be filed within 72 hours after death with the Maryland at Hygiene. A try green of other then "naturel" or items 23e or 28e-f show event, the Medical Examinar must be notified at	y Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			of Hispanic Origin? uban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0-	14. Race - Americ Black, White,	
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and	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	e, Maiden	Sumame)	
>		P	Thomas R. Bailes J		101.11.11		Cora M		-		
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Ē	Page ment ant: H		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Homovai Hom State	Bayview (1 110	2007	Balt	imore Ci	ty, MD.
Baitimor	permit. Pages Department of h Important: If ite eny Injury or of other.		21. Signature of Funeral Service Licen	993	₫ 71	nnelly 10 Soll	Funeral I ers Point	Home Of I	Dunda Dunda	ılk,P.A. ılk,MD. Z	1222
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=	ysicia s certi directo	To Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatien	t 3 DOA	Note	eath Check only		6 □Other (Specify	4
IVISION O	nding Ph ath. r: After thi e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of injury (Month, Day Ye	28b. Time of	28c. In		28d. Describe			0
	To the Hospital or Attending Physician: The law requires that the withing 4 hours after death. To the Funeral Director After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, str Specify)	eet, factory, offic	е	28f. Location (City or To		d Number or Rura)	l Route Number,
:	ine Hosp in 24 hou the Fune ipletely fil	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of m iner: On the basis of exa and manner stated.	amination and/or inv	occurred at the restigation, in m	time, date and place y opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To T	Σ	29b. Signature and title of certifier			0	nse number			e signed (Month,	
				M.D.		KE	5 001	7	vover	n ber 06	,2007
	12		30. Name and address of person who of				DEASTER	AVE RAIT	Timasos	F MATO 212	24
1	Sta Registra		31. Date filed (Month, Day, Year)	Registrar's	Signature		- FILGIEN	- NATUDIALI	CONTON	WID ZIZ	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year November 8, 10:30P M Viola Ε. Brose 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Nursing Home Westminster Carroll 8. Date of Birth (Month, Day, Year)
Sept. 23,1908 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F 99 Yrs. Director 215-14-6670 MD Usual Residence of Decedent 10b. County 10a, Stale 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 XNo Directo Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 73 Hanover Road 21136 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home le marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental F . Pages 1 and 2 should by trinent of Health and Menta tent: If item 27 is marked Irving T. Wilhelm Grace Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3940 Sells Mill Road, Taneytown, MD E. Paul Brose Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. NOV. 12 2007 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home nie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Cerwsell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physicien ician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant al time of death 5 Other (specify) ed by the a o Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificete Division of Vital 1 Yes the Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Magner of Death 1 Z Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation s after dea....al Director: After Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 9:55 PM lovember 200 Helen J. Birchess /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs.
Wonths | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 197-03-3932 87 Director Jan 3, 1920 Pennsylvania Usual Residence of Decedent filed within 72 hours atter death with the Maryland Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Glen Burnie Anne Arundel Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Furnlea Dr. 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 1⁄2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the 10 Homemaker permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominic Makarewicz ပ Alexandra Niedzwiecka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damian E. Burchess MD (son) 105 Furnlea Dr. Glen Burnie, Md. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cem. 11/10/07 Shenandoah, Pa. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. monucau 4001 Ritchie Hgwy. Balto, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAL AERYTHEMIA 40 minute /Medical Due to (or as a consequence of): Examiner 24 hour SEPTIC SHOCK Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed FISTULA 2-3 Days ARTERIO - VENOUS INFELTED Due to (or as a consequence of): 68760 attending physician Physician/Medical as the t IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes AR 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy The performe certificate 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl) one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပို After this 28a. Date of Injury (Month, Day Year) funeral 27. Manper of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐ No To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide OPERATING ROOM hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as states.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State Registrar	State of N	Maryland		artmen			and M		giene	חחק	36146
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	/Medic		Frank M. Boyle					- 15			11	08	200	
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	ath wi	ral	1436 Virginia Av					1144					U.S.A	. •
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Maryland	2 should be and Menta is marked raumatic ev	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address	(Street a			al Route Numbe	er, City or Te	own, State, .	Zip Code)
Σ,	12 를 2		Mrs. Maureen Stan	ton / Dau			6 Vir			enue	Seve	ern, N	1D. 2	1144
Baltimore,	00		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from Sta	20b. Plac cer	ace of Dispos metery, cren	sition (Nam natory or o	ne of ther place			ate		•	Town, State
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Ä	The lay ate has page 2:	mo									autop perfoi 1∐ Yes	sy med? 2 No	prior to death? 1 ☐ Yes	completion of cause of
/ita	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or		1 1 1 1 2 3	2,4110
Division or Vital Records,	Attending Physician: r death. ector: After this certific: by the funeral director,	2	1 ☐ Yes 2 No 27. Manner of Death		ntient 2 ☐ EF				4 LI Nur		ne 5 Resid			ecify)
on	ding I h. After funer	tion	1 Natural 5 ☐ Pending	28a. Date of In (Month, D		8b. Time of Injury	M 28	Bc. Injury Work' 1 □ ∨	at ? ′es 2 □ N	- 1	28d. Describe h	ow injury o	ccurred	
VISI	Atten r deat ector; by the	fica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in	injury - At home	e, farm, stre			C3 Z	-	8f. Location (S	treet and N	lumber or Ri	ural Route Number,
ā	ital or irs after ral Dir	Certification:	4 Tromicide		etc. (Specify)						City or Tow	n, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifler (Check only one) 1 Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examination	edge, death n and/or inv	occurred a restigation,	at the tim in my op	e, date and pinion, deat	d place, a th occurre	and due to the ded at the time, d	cause(s) an	d manner as ace, and due	s stated. e to the cause(s)
	To the within To the comple	Ž	29b. Signature and title of certifier	3.10			29c.	License	number		2	29d. Date s	igned (Mont	h, Day, Year)
	$\langle $		· Cordi	when y	<i></i> ,			SYC	87C				191	07
1	0		30. Name and address of person who	completed cause of	death (Item 23	3a) (Type, F	Print)				0 1	0		o7
ì	Stat	te	31. Date filed (Month, Day, Year)	Regis	etrar's Signatur	0	DA B	m	Olin)	aus	Rd	rasa	deno	a madisti
	Registra		NOV 1 3 200	7 March	J. 15.	A CORN	EL B							

DHMH 17 Rev 1/2001

				For State	State of Ma	-	•	Health and N	Mental Hy	gien	7007	00117
				1 - State Registrar			Certificate o	f Death			2007	36147
		Physici		Decedent's Name (First, Middle, La KERMIT	ist)		BRYNES		2. Date of De Month NOVEMBE	Da	2007	3. Time of Death 7:20P M
		/Medic Examir		4a. Facility Name (If not institution, given	re street and number)			n, or Location of Death			: County of Death	1
	1			BROADMEAD			COCKE	EYSVILLE			BALTIN	10RE
		Funeral				(In yrs. last birt	Months Day		8. Date of Bir (Month, Da 10/02/1	rth ay, Year	9. Birthp	place (State or Foreign
		Director		092-12-19/3	10 M 20 F	92	rs.		10/02/1	1915		NY NY
		and w		Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town	or Location				1	10d. Inside City Limits
		filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tiems 23a or 28e-f show int. Its Madical Exemitier mast Le matified at	ō	MD BALTII	4ORE	COCK	EYSVILLE					1 ☐ Yes 2 X No
		r 28e-f	Funeral Director	10e. Street and Number			10f. Zip Cod	9		10g. Ci	tizen of What Cour	ntry?
		h with	a D	13801 YORK ROAD	#204A		21030)			U.S.A.	
2		deat ems	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of	of Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No	o-	14. Race - Americ Black, White,	
à	98	or Item	F	1 Never Married 2 Married	1 ☐ Yes 2 🕻 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🔯 N		, , , , , , , , , , , , , , , , , , , ,			WHITE
:30pm	21215-0036	72 hours after o "natural", or Iten	d by	3 Widowed 4 Divorced		1.100	,			105 6		
10	15	in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Oc (Give kind of work do life. DO NOT use rel	ne during most of work	king	160. F	(ind of Business/In	dustry
7	212	s within jiene.	mo M	Elementary/Secondary (0-12)	College (1-4or 5- 4	ELE	CTRICAL EN			Α	EROSPACE	
`		be filed ital Hygi od other event.	e C	17. Father's Name (First, Middle, Las.)			18. Mother's Nam	ne (First, Middle	, Maidei	n Surname)	
	Maryland	o d a b	To Be	SAUL		BRYN	ES	CLARA				ROLL
	lary	2 sho		19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Stre	eet and Number or Ru	ral Route Numb	er, City	or Town, State, Zip	Code)
7		1 and 2 Health tem 27		LORE BRYNES / W	IFE			ROAD #204A				
7	ore	8 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	KING D	Disposition (Name of y, crematory or other I AVID MEMOR	3/ace) 11/1	Date 1/2007		ocation - City or To LS CHURCI	
10/11	altimore,	: Pag tment tant: jury		`4 Donation 5 ☐ Other (Speci	fy)	KING D	PARK			1355		- X-24-22
11	Bal	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	nsee		22. Name and Ad 8900 RE	dress of Facility 5(ISTERSTOWN				, INC. MD 21208
				23a. Part V. Enter the disease, or con shock, or heart failure. List only	aplications that caused	the death. Do n	ot enter the mode of	tying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
4		Pnysician		Immediate Cause (Final disease or condition	ESCHE	MICH		DISEASE			+E	Onset and Death
•	1	/Medical		resulting in death)	Due to (or as a	consequence		0150150			1.1	J. 4-10.5
		Examiner	L	Sequentially list conditions,	b							
	-	ed isit	Examiner	Sequentially list conditions, if any, having to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dia to (or as a	consequence o	n;					
	68760,	ificate be executed g physician and as the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a	consequence of	of);					
	09/	siciar buria	ai		d							
M	89	:= C0 et	edicai		u							
Ti.	Вох		Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 □Ectopic pregna	201			23d. Date of delive	•
\geq		that the death cer ed by the attendir detached for use	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t		5 ☐ Other (specify,				Month	Day Year
BRYN	P.0	at the by the	hys	9 🗆 Unknown								
EX.		res tha igned be del	by	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause	given in Part I.			_/	the cause of death?
(2)	orc	w requir been s should	eted	Hapartais	11	1.						
	Records,	e law has b	ηbje	Atnol F	16/11/2	ron			24a. Was		24b. Were auto prior to co death?	opsy findings available empletion of cause of
1	E								1 ☐ Yes			2□ No
<u> </u>	Zit.	Physician: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea				
7	of	ding Phys	: To	1 ☐ Yes 2 12 No 27. Manne of Death	28a. Date of Injun	nt 2 ER/Out	patient 3 DOA	4 Winursing H	ome 5 Res 28d. Describe		6 □Other (Special ary occurred	у)
2/	on		tior	1 Natural 5 Pending 2 Accident investigation	(<i>Month, Day</i> n	Year) Ir		njury at Vork? ☐ Yes 2 ☐ No				
XCRN!	Division of Vital	l or Attence after death Director:	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, far	m, street, factory, office	сө			nd Number or Rura	al Route Number.
	Ö	s after s after of Dire	Certification:	4 Hornicide	building, etc.	. (Specify)			City or To	iwn, Stat	θ)	
		To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical (nysician: To the best o miner: On the basis of and manner stat	examination and						
		To the h within 24 To the F complete	Med	29b. Signature and title of certifier			29c. Lio	ense number		29d. Da	ate signed (Month,	Day, Year)
		- 5-0		Barban	CALLAN	11, m	20 1	3839	2	/	1/8/2	007
		/		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, Print)				, ,,,,	21031
		D		BARBARA CA	RROLL, M	10,1	3801 YO	ORK RD.	, COCK	E	15VILL	E, MD
		Sta Registr		31. Date filed (Month, Day, Year) NOV 1 3	007	r's Signature	Grand			ı	,	

			Please	Type or Prin				-	_	
			1 - For State Registrar	State of Ma	-	partment of I <i>ertificate of</i>	lealth and M		ene g. No2 0 0 7	36118
	r = r		Hegistrar Decedent's Name (First, Middle, Las	nt)		Crimcaic or	Death	2. Date of Death	1	3. Time of Death
į.	Physici /Medic		Veronica	В	eling			Nov 11	, 2007 Year	12:55a ™
	Examin		4a. Facility Name (If not institution, give Stella Maris Ho	street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)
	Director		213-09-6/35	□M 2 X]F	91 Yrs.	Months Days	Hours Min.	(Month, Day, 9-13-1		yland
	land bw It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-f sh	ctor	MD N/	'A	Baltim	ore				1 X Yes 2 □ No
	vith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	eath v	Funeral	714 S. Lakewood	Avenue 12. Was Decedent E	verin IIS 1	212		cify Ves or No-	USA 14. Race - Ame	rican Indian.
ဖွ	after d or iten niner		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give)		Hispanic Origin? (Spe pan, Mexican, Puerto I	Rican, etc.)	Black, Whit	e, etc.
003	ural",	d by	3 x Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 ☑ No			Specify: Wh	
7	be filed within 72 hours after death with the Maryland rital hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	(Gi	cedent's Usual Occup ive kind of work done e. DO NOT use retire	pation during most of workir d)	ng 1	6b. Kind of Business/	Industry
212	ed with	Com	6	N/A		Homemake			Home	
and	be do do	To Be (17. Father's Name (First, Middle, Last) Walter Panek				18. Mother's Name	, , , , , , , , , , , , , , , , , , , ,	,	
Ž	12 should be filed w n and Mental Hygie 7 Is marked other ti raumatic event, th	10	19a. Informant's Name/Relationship (7	Type. Print)	19b. Ma	ailing Address (Street	Maryann and Number or Rura		K1EW1CZ City or Town, State, 2	Zip Code)
Baltimore, Maryland 21215-0036	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		Veronica Krzywi							
ore	ges 1 t of He If iten or oth		20a. Method of Disposition 1☑ Burial 2 □ Cremation 3 □	Removal from State		sposition (Name of crematory or other pla		4-0/	20c. Location - City or	Town, State
ᆵ	permit. Pag Department Important: I any injury o		4 Donation 5 Other (Specify 21. Signature of Funeral Secretary	9	Sacred		Jesus (Dundalk,	
Ba	Deperment Important		W Market Street						imore, M	al Home,PA D 21222
1	71		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olica in s that caused tone cause on each line	· ·					Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a BREAST CA						Onset and Death
	Examiner			Due to (or as a	consequence of):					
à	, =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury	b. — Due to (or as a	consequence of):					
	executeo in and ial-transit	Examine	Cause (Disease or Injury that initiated events resulting in death) Last	c	consequence of):		-			
760	be icia	=		.d						
189	rtificat ng phy as the	Medic	IF FEMALE:							
ROX	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1□Live birth 2	Fetal death	3 □Ectopic pregnanc	y		23d. Date of del Month	ivery Day Year
o.	the de	nysic	1 □Yes 2 X No 9 □ Unknown	4□Pregnant at t 9□Unknown	irrie or death	5 ☐ Other (specify) _				
S,	w requires that the d been signed by the should be detached	by PI	Part II. Other significant conditions of	ontributing to death but	not resulting in the	e underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord G	requir een si hould	sted	1					1 □ Yes	s 2∏ No 3∏ Pi	obably 4 X Unknown
Vital Records,	he law has b ge 2 s	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
<u>ra</u>		0	25. Was case referred to medical				26. Place of Death	1 Yes 2		2 □ No
o >	Physici this ceral direc	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatien		Helit 3 DOA	ner: 4□ Nursing Hon		nce 6 X Other (Spe	cify) HOSPICE
	tending P eath. tor: After t the funera		27. Manner of Death 1 Natural 5 □ Pending investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Year) Injur	y Wo	ryat 2 rk?]Yes 2 ∐No	8d. Describe how	w injury occurred	
Division	or Attending Physician: after death. Director: After this certific in by the funeral director,	ficat	3 Suicide 6 Could not be	28e. Place of injur	y - At home, farm,	street, factory, office		8f. Location (Stre	eet and Number or Ri	ural Route Number,
S	tal or rs after al Direction bed in b	Certification:	4 ☐ Homicide determined	building, etc.	(Ѕреспу)			City or Town,	State)	
	To the Hospital or Atter within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of piner: On the basis of a and manner state	examination and/or	eath occurred at the ti r investigation, in my	ime, date and place, a opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within ?	Mec	29b. Signature and title of certifier) and mariner state		29c Licens	se number	29	d. Date signed (Mont	h, Day, Year)
)	1			/ -			13725		11/12/0	57
	4		30. Name and address of person who c				TWONTER -	m 01000	,	
	Sta	te	DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)	32 Hegistrar	ANEY VAL	LEY KD. T	'IMONIUM, N	m 21093		
	Registr	ar	NOV 1 3 20	007 /	's Signature	a reserve				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month gay 2007 Patricia Worrell Cavendish Novemer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 5259 Five Fingers Way Columbia If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Feb. 7, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 😾 F Yrs 86 Director 499-34-4055 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f shov notified at 1 ☐Yes 2√ No Director Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code a or items 23a 5259 Five Fingers Way 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ Teacher Big Walnut Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noel S. Worrell Irene S. Thacher ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a William James Cavendish (Son) 9055 Phillip Dorsey Way Columbia, MD 21045 Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 11-13-2007 4 □ Donation 5 □ Other (Specify) Catonsville, Maryland 22. Name and Address of Facility Witzke Funeral Hores, Inc. 21. Signature of Funeral Service M01050 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Concer **Physician** mouths /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Entar underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): burial Division or Vital Records, P.O. Box 68760. physician the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy page certificate 2X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury after death. I Director: Al 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital

Registrar DHMH 17 Rev 1/2001

To the

29a. Certifier

(Check only one)

MARRY MOORE

29b. Signature and title of certifier

100mm us 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> Dorsey Hall Drive 32. Registrar's Signature

Miller .

4801

Medical

State

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

121461

Ellicott City

29d. Date signed (Month, Day, Year)

NOVEMBER 11 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2007 William Ray Coffman November 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1332 James Street Baltimore n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F 52 Director April 1955 Mary land 220-64-2591 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at MD n/a Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 1332 James Street U.S.A. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: white Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dock Loader Shipping and Receiving 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Coffman Ada Bernice Shover ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy L. Coffman/Wife 1332 James Street Baltimore MD 21223 20b. Place of Disposition (Name of cametery, crematory or other place)
Glen Haven Memorial 11-14-2007 Glen Burnie, MD
Park

22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Rd. Lansdowne MD 21227 Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anicez YEG 125 **Physician** 4 -a5 Tal: /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. s been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy page performed Yes 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this spital or Attending Phy nours after death. neral Director: After this / filled in by the funeral d 27. Manner of Duath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature of title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:01 PM Z007 November .I. W. CHEEKS 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) APRIL 28 1932 VIRGINIA Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 251-44-0951 75 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, <u>the Medical Examiner must be notified</u> Director PRINCE GEORGE'S CAPITAL HEIGHTS 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9511 EUGENIA PARK STREET 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4TH MECHANIC PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MOZON CHEEKS MARTHA ANN CHEEKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13302 BLACK DUCK COURT UPPER MARLBORO, MARYLAND Department of Health a Important: If item 27 is any injury or other trau once. CHIQUITA K. TANNER/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEMETERY 11/16/2007 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Resp Physician /Medical Due to (or as a consequence of **Examiner** Exacerbotions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Emphysema Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a Was an autopsy performe Yes 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

DHMH 17 Rev 1/2001

29c. License number

George

November 13th 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36152

	- For State Certificate of De	ath	Reg. No.	
Physician/ lical Examiner	egistrar 1. Decedent's Name (First, Middle,Last) Joan Marie Cimino		2. Date of Death Month Day November 9, 2007	3. Time of Death 'ear 1415 hrs
	4a. Facility Name (if not institution, give street and manual)	ty, Town, or Location of Death andailstown	Baltim	ty of Death ore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth(MM/DD/YY April 21,1944	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	wn		10d. Inside City Limit:
the Maryland a or 28a-f show tiffed at once. Director	10e. Street and Number	. Zip Code		What Country? ates Of America
death with the Maryland or items 23a or 28a-f show must be notified at once.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	21133 cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puerto	pecify Yes or No- 14. R	ace - American Indian, Black, /hite, etc.
s after death with rral", or items 23 uiner must be no by Funeral	or Dates:	sual Occupation (Give kind of	work done 16b. Kind o	fy: White f Business/Industry
2 hour "natu	Elementary/Secondary (0-12) 10 College (1-4 or 5+) Nurses	of working life. DO NOT use ret Aide	Heal	th Care
21215-0036 build be filed within 7 I Mental Hygiene. marked other than ic event, the Media To Be Comple	17. Father's Name (First, Middle, Last) Tohn Milton Willingham	Margare	e (First, Middle, Maiden Sume et Kahle	
MD 212 nd 2 should be alth and Menti m 27 is mark raumatic ever	19a. Informant's Name/Relationship (Type, Print) Michael J. Cimino (Son) 19b. Mailing Ad 2827 Ba		, Finksburg, N	Town, State, Zip Code) Aaryland 21048 ion - City or Town, State
TOFE, IM ages 1 and 2 nt of Health it: If item 2 other traur	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Lake View Mem	olace) porial Park 11.	 /13/07	ville, Maryland
BAILIMOIE, permit. Pages I at Department of Her Important: If ite injury or other tr	21. Signature of Funeral Service Licensee 22. Nam 7. Order Species 22	e and Address of Facility Lo: Liberty Road,	ring Byers Fu Randallstown	neral Directors , Maryland 2113
Physician 'Medical aminer	art I. Inter the disease, or complications that caused the death. Do not enter the refailure. List only one cause on each line. Immediate Cause (Final disease a Methadone and al razolam in		or respiratory arrest, shock, o	Approximate Inter Between Onset a Death
	or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): b. Due to (or as a consequence of):			
ed nisit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
execut an and al - tra	XUNPENDED AMENDED 27,28a-f, perME,g873	, 11/27/07 TT	23d. D	ate of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certification: To Be Completed by Physician/Medical Exhibital Exhibital Certification: To Be Completed by Physician/Medical Exhibital - Transit certification: To Be Completed by Physician/Medical Exhibital - Transit certification: To Be Completed by Physician/Medical Exhibital - Transit certification: To Be Completed by Physician - Transit certification: To Be Completed by Physician - Transit certification - Transit certificat	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	death 3 Ectopic preg	nancy Mo	nth Day Year
res that the deat signed by the at be detached for d by Phys		lerlying cause given in Part I.		contribute to the cause of death?
(ecords, Pare law requires the law requires that has been signage 2 should be dompleted by			24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death?
I Reconstruction The land The land The land This land to the land to the land the la	25. Was case referred to medical	26.Place of Death (Che		1 Yes 2 No
n of Vital F fing Physician: After this certifi funeral director,	27 Mapper of Death 28a. Date of Injury 28b. Time of Injury	ury 28c. Injury at Work?	28d. Describe how injury	e 6 ✓ Other: Scene occurred
Division of Vital Records, tan or Attending Physician: The law require as after death. In Director: After this certificate has been sittled in by the funeral director, page 2 should be ertification: To Be Completed.	Natural Accident Accident Suicide Dending Investigation Fnd 11/9/2007 Fnd 2:05 Repending Investigation Fnd 11/9/2007 Fnd 2:05 Zee. Place of Injury - At home, farm, street,	factory, office building, etc.		Number or Rural Route Number, ourt Randallstown,
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the ledical Certificatif	20 - Contifier	d at the time date and place.	and due to the cause(s) and r	nanner as stated.
To the Hos within 24 h To the Fun completely	290. Signature and this of contino	29c. License number O.C.M.E.	29d. Da	te signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)			
L pereil	Ling Li, MD Assistant Medical Examiner 111 Penn Street	, Baltimore, MD 21201		

07-08664 Joyce Lynn Colbert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36153

			- For State	Certifica	te of Death		Reg. I	No.	
	Physici	_	1. Decedent's Name (First, Middle,Last)				2. Date of Death	ay Year	3. Time of Death
Medic	cal Exami		JOYCE LYNN COLBERT				Month Da November 7,		1718 hrs
			4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Oakland	Location of Death		4c. County of Dear	h
			728 Boy Scout Road			Tight to Oakle	lo Data of Black (ethology (Ctato or Foreign
	Funeral			(In yrs. last birth	day) If Under 1 Yea Months Days			C	rthplace (State or Foreign ountry)
	Director	L	401-68-4161 1 M 2XF	48	Yrs.		3/27/	1959 KI	ENTUCKY
	Α.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	ow any		MD GARRETT	•	LAND				1 Yes 2 XNo
1	yland -f show once.	į.	10e. Street and Number		10f. Zip Code	_	100	Citizen of What Co	
5	th the Maryland 23a or 28a-f sho notified at once.	Director	728 BOY SCOUT ROAD		2155	50		JSA	,
	ith the 23a c notifi		11. Marital Status 12. Was Decedent I	Type in II C	13. Was Decedent of His				rican Indian, Black,
and the same of th	ath w	Funeral	1 Never Married 2 Married Armed Forces?		If Yes, specify Cubar			White, etc.	
	ter de ", or er mu		3 Widowed 4 X Divorced If Yes, Give Year	X No	1 Yes 2 X No	specify:		Specify: WI	HITE
	urs af tural' amina	â	15. Decedent's Education (Specify only highest grade com		ecedent's Usual Occupa	tion (Give kind of v		6b. Kind of Business	s/Industry
	72 hor	ete	Elementary/Secondary (0-12) College (1-4 or 5	+) d	uring most of working life		red)		
036	ithin ne.	Completed	5+		VETERINA	ARIAN		VETERIN	NARIAN
5-0036	led wit Hygien other	ैं	17. Father's Name (First, Middle, Last)				(First, Middle, Mai	den Surname)	
7	LILI Muld be fil Mental F marked c event, t	å	GEORGE PAUL COLBERT			JEAN P			
MD 24	hould hould of Me is ma	٦ ا	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Stree				
	Health and item 27 is		JEAN P. COLBERT moth 20a. Method of Disposition		315 JAMAIO			Oc. Location - City	
ğ	es la of He If ite		1 Burial 2 X Cremation 3 Removal from Sta	te cremato	ry or other place)			*	MORE, MD
<u>.</u>	Pag ment tant: or of		4 Donation 5 Other Specify:	GREEL	N MOUNT				
Raltimore	Deficient Page 1 and 2 should be filed within 72 hours after death with the Maryland opermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service Licensee		22. Name and Address 16924 YC				& SONS CO.
			23a. Part I. Enter the disease, or complications that caused	the death. Do not					Approximate Interval
port of a	Physician 'Medical		failure. List dnly one cause on each line.						Between Onset and Death
	kaminer		Immediate Cause (Final disease or condition resulting in death) a. Complication Due to (or as a conse		onic alcoholis	<u>n</u>			
			Sequentially list conditions, b.	4401100 01/					
		ner	if any, leading to immediate cause. Enter Underlying Cause	quence of):					
		Examine	Cisease or injury that initiated events resulting in death) Last	quence of):					
2003	uted id ransit		d.						
V	ficate be executed g physician and s the burial - transit	Medical	x unpended AMENDED #23a,27.pe	-ME ~976	2/1/09 1111				
S	ate be hysic le bur	Med	IF FEMALE: 23c. If yes, outcome	ne of pregnancy				23d. Date of deliv	
787	ertific fing p		23b. Was decedent pregnant in the past 12 months?	2		Ectopic pregn	ancy	Month	Day Year
89 >0	eath certifications are as	/sician	1 Yes 2 No 9 V Unknown 9 Unknown	time of death 5	Other (Specify)				
0	that the done of by the detached	Phy	Part II. Other significant conditions contributing to death	but not resulting	in the underlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
	ires that signed be deta	<u>ام</u> ا					1 Yes	2 No 3 P	robably 4 🗹 Unknown
5	w require to been si should b	Completed					24a. Was an	24b. Were	autopsy findings available
Ş	law r has b	힐			···· -		autopsy perform	ed? death	
ď	vican reconsisting the law his certificate had director, page 2				26 Dine	e of Death (Check	1 Yes 2	No 1 🗸	Yes 2 No
<u></u>	ician ician s certi	Be	25. Was case referred to medical examiner?	nt 2 ER/O	utpatient 3 DOA	TOthor:		esidence 6 🗸 Ot	ner: Scene
2	Physic er this eral dir	은	1 Ves 2 No 1 Inpate 27. Manner of Death 28a. Date of Inju			ury at Work?	28d. Describe ho		
9	nding Pl th. T. After e funera	io.	1 X Natural 5 Pending (Month, Day,Y	ear)	1	Yes 2 No			
.0	Atte	icat	2 Accident Investigation 28e. Place of In	jury - At home, fa	rm, street, factory, office	building, etc.	28f. Location (Str	eet and Number or	Rural Route Number, City
O o obracio of Vital Boards	talor rs afte red in	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, Sta	te)	
	Hospi 24 hou Funer ely fil		29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, dea	th occurred at the time, o	tate and place, an	d due to the cause(s) and manner as s	tated.
	To the Hospital or Attending Physician: The law requires that the death certificate death certificate death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of exa	mination and/or in	nvestigation, in my opinio	n, death occurred	at the time, date an	nd place, and due to	the cause(s)
	F 18 F 8	ĕ	29b. Signature and title of certifier		29c. Licen	se number	OCME	29d. Date signed (i	Month, Day, Year)
			Theodore 11 16 00	71	0.0	.M.E.		November 8, 2	2007
	16		30. Name and address of person who completed clust of completed clust of complete clust of complete clust of complete clust of complete clust of complete clust of complete clust of complete clusters.	eath (Irem 23a)	3/				
	The gran		Theodore M. King, Jr., MD. Assistant M	edical Exam	iner 111 Penn S	treet, Baltimo	re, MD 21201		
	```	tate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	Angel ?	-			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 873 11-13-07 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marian Virginia Campbell 11:00A M 4, November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House of Laurel Laurel Prince George 8. Date of Birth (Month, Day, 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🛛 F 93 Aug 8, 1914 Washington, DC Director 216-40-5013 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1X Yes 2 No Director MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7700 Cherry Lane #115 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ 3 X Widowed 4 ☐ Divorced White Completed Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Raymond James Henrietta French 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 S. California St. Helena, Montana 59601 Patricia J. Greene /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Nov 10, 07 Brentwood, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Se M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tre. List only one cause on each line. 23a. Part1. Enter the dis shock, or heart fall Immediate Cause (Final **Physician** 1800 01 disease or condition resulting in death) /Medical Due to (or as a a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical asi attending properties of the second IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ed by the a 1 ☐ Yes 2 The No 9 ☐ Unknown 9□Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate he funeral director, page 2 **X**N 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assistal 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No s after death.

I Director: A
od in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

Am

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mi

gistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrat Certificate of Death 1 Decedent's Name 2. Date of Death 3. Time of Death **Physician** 8-31 04 2007 /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ar If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10-17-1917 7. Age (In yrs. ast birthday) 5. Social Security Number **Funeral** Min Months Hours \$15-16-703 1 M 20 a 0 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at 1 **27**es 2 □ No Director MD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 407 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 To If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame Be icinda 2 ames 19a. Informant's Name/Relationship / ype, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, t of Health Cto.MD 21239 Saughter 407 20a. Method of Disposition

1 Burial 2 □ Cremation Date 20c. Location - City or Town, State 3 Removal from State Department of important: if any injury or one. 10/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Betwee Onset and Dea 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter t set and Dear Immediate Cause (Final andlac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) halohatty Examiner 44 hoxec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner attending physicien and for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2VI No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referre to medical examiner? Be 26. Place of Death (Check only one) Other Certification: To 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. May er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) State NOV 13 Registrar

29b. Signature

30. Name ap

d title of certifier

ddress of person who completed cause of death (Item 23a)



29d. Date signed (Month, Day, Year) 5-0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year NOVEMBER 8, 2007 **Physician** 235 am MATTHITI CKYYOU /Medical Α. 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner maryland General Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Yrs. Director 219-52-3409 MARCH 23, 1951 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show be notified YYYes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 2249 EUTAW PLACE 21217 by Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry and 2 should be filed within 72 lealth and Mental Hygiene. m 27 Is marked other than "nat (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental MATTHEW THORNTON JULIA BAYLOR 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat once. RITA J. CKYYOU/DAUGHTER 5515 BOWLEYS LANE, APT 1A; BALTO., MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) CEDAR HILL CEMETERY 11-14-07 GLEN BURNIE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Atheros claristic disease or condition resulting in death) 10 Yus (and oversulon /Medical Due to (or as a consequence of): Examiner 3 Yunt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as(a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1Æ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1□ Yes or Vital Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 DER/Outpatient 3□ DOA 1 1 Yes 2 No 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar strell

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32. Registrar's Signature

Gutar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

31. Date filed (Month, Day,

			State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg No 2007 36	157
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death	
ı	Physici /Medic		Donis Month Day Year	0am ^M
	Examir			
	\$		EastPoint Rehabilitation Center Baltimore Baltimore	
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 M 2 S F  7. Age (In yrs. last birthday)  1 Months Days Hours Min.  Nonths Days Hours Min.  8. Date of Birth (Month, Day, Year)  9. Birthplace (State Country)	
			220-24-5026 85 Sept 9,1922 Marylan Usual Residence of Decedent	<u>d</u>
	rylan how	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside C	City Limits
	ne Ma 8a-f s ptified	Director	MD Baltimore Baltimore 1 RY	s 2 No
	with the	Ę	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	leath ns 23 must	Funeral	U.S.A.  10.46 North Point Rd 21222 U.S.A.  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
٥	after or iter			
2	172 hours after death with the Maryland "natural", or items 23a or 28a-f show kdical Examiner must be notified at	d by	3. Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2. No Specify: Specify: Black	
215-0036	"natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)	_
7 17	withii iene. • than	dmo	Elementary/Secondary (0-12) College (1-4or 5+) Housewife home	
0	afiled al Hyg other	Be C		
yland	wild by Menta arked	10E	Harvey Brown Pearl Smith	
Mar	2 short and is ma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e,	1 and Health em 27 ther t		Gloria C. Franklin/daughter 6220 Catalpha Rd. Baltimore, MD 21214  20a. Method of Disposition Date   20b. Place of Disposition (Name of   Date   20c. Location - City or Town State	
	ages ent of tt: If it y or o		1 Deviate 2 Comparison 2 Demonstrate Comparison Charles Community or other place)	
Бант	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.	1	21. Signature of Funeral arrive Lists 22. Name and Address of Facility	, MD
Ď	an per		CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximation of the mode of dying, such as cardiac or respiratory arrest, Interval Be	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. On partie Load Tailure  Onset and	Death
	/Medical Examiner		Due to (**) as a consequence of):	
V	V 4 (A)	er	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause Disease or injury	
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,00,00	icate be executed physician and s the burial-transit	dical	d	
×	death certifica a attending ph d for use as t	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery	
ă	death e atter	Physician/Me	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No  4 Pregnant at time of death 5 Other (specify) Month Day	Year
	at the by the	hys	9 □ Unknown 9 □ Unknown	
Z,	w requires that the death cer been signed by the attendin should be detached for use	ρ	23e. Did tobacco use contribute to the cause of	
2	requi	eted	1 Yes 2 No 3 Probably	Unknown
ב	has las ge 2 s	Completed	24a. Was an autopsy findings autopsy prior to completion of performed?	available cause of
5	an: Ti tificate or, pa	ပိ	OF Man ones referred to made at	
>	ysicis is cert direct	O B	examiner?	
2	ding Physician: The lav n. After this certificate has funeral director, page 2:	L H	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
2	tendi leath. tor: A the fu	catio	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be	
5	after of Direct in by	Certification:	4 Homicide  4 Homicide  4 Homicide  4 See. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	nber,
	spital nours neral / filled			
	To the Hospital or Attending Physician: The law requires that the death certificate hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated.	s)
	To T To 1	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
			11 18 2007	,
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Madai Chardon 1845 Dakwood La He ID Colou Burn	30
	Sta		31. Date filed (Month, Day, Year)  32 Registrar's Signature	116
	Registra	ar	NOV 1 3 2007 Like the first first the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician O 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville Baltimore 2900 Andrea Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-03-1948 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F 215-46-9301 59 Yrs. Director Marvland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Parkville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2900 Andrea Avenue 21234 USA Completed by Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Folces.

No Ses, Give Reserves 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +4 Insurance Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen Gleason Anthony Cortolillo မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Andrea Ave, Parkville, Md Kathleen Cortolillo/Wife 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Timonium, 11-16-2007 4 Donation 5 Other (Specify) 21. Signature of Fune all ervice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 1050 York Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed and Due to (or as a consequence of) bunal Box 68760. physician Physician/Medical the as attending properties for use as IF FEMALE: f yes, outcome pf pregnancy □Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached i P.0. 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Onknown 1 ☐ Yes been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s autopsy performed? es 2 No certificate 1∐ Yes ospital or Attending Physician: hours after death. director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient ို this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 30. Name and address of person

31. Date filed (Month. Dav. Year)

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who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Rexford Charles Deery 2007 10:15 PM November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Dayton 13549 Argo Drive 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1**№**M 2□F Days Hours 68 219-34-7505 June 20, 1939 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Dayton Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 13549 Argo Drive 21036 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🗵 No Specify: Specify: White 20 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Williams Charles H. Deery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dayton, MD 21036 13549 Argo Drive Adele M. Deery (Wife) 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Crestiawh Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11-12-2007 Marriottsville, MD Gardens 22 Name and Address of Facility Homes, Inc Columbia, MD 21045 5555 Twin Knolls Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2D No 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year)

requires that the death certificate be executed burial-tran and attending physician Box 68760. Physician/Medical the 1 use as for P.O. I signed by the a Division or Vital Records, þ Completed peen s certificate has birector, page 2 s or Attending Physician; director, Be within 24 hours after deam.

To the Funeral Director: After this of the funeral director and the funeral director. 2

Funeral

Director

28a-f show

s 1 and 2 should be filed within 72 hours after death with is fleatth and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or?

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 Is marked othe any injury or other traumatic event,

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner

must be notified

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certification who completed cause of death (Item 23a) (Type, Print)

ell Lane Clarksulle MD 21029

State Registra

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Medical

31. Date filed (Monti Year

1gna egistrar's Signature

To the Hospital

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

			1 - For State Registrar	State of Maryla	Cei	rtificate of Deat	h	Reg. No.	07 36160
7	) #4		1. Decedent's Name (First, Middle, L	ast)			2. Date of Month		3. Time of Death
	Physici /Medic		Joann 1	70-10 6	D. chs	07	11	Day	2007 1115-PM
	Examir		4a. Facility Name (If not institution, gi	ive street and number)		4b. City, Town, or Locatio	n of Death		nty of Death
4			170 wa rel 10 m. 5. Social Security Number 6.	Sex 7 Ane (In ve	s last hirthday	If Under 1 Year If Und	er 24 Hrs 9 Date of	110	9. Birthplace (State or Foreign
Ęź	Funeral Director		463-72-2748 Usual Residence of Decedent	1 M 2 B +	62 Yrs.	Months Days Hours	Min. (Month, Jan.	Birth Day, Year) 11, 1945	Scotland
	yland		10a. State 10b. County	10c. C	City, Town or Lo	cation		-	10d. Inside City Limits
	e-f sh	ctor	Maryland Howard		Columb	ia			1 ☐ Yes 2X No
	or 28	Dire	10e. Street and Number	1 7 5		10f. Zip Code			of What Country?
	s 23a	rai	10756 Autumn S			21044			5.A.
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Experiment must be notified at once.	by Funeral Director	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic ( f Yes, specify Cuban, Mexic I ☐ Yes 2 Å No Specif		No- 14. R B	ace - American Indian, lack, White, etc. cify: White
Ö	72 hou	ted	15. Decedent's E	Education	16a. Deced	lent's Usual Occupation kind of work done during m		16b. Kind of	Business/Industry
Maryland 21215-0036	ithin 7	Completed	(Specify only highest gi	College (1-4or 5+)	lite. I	OO NOT use retired)			
2	led w tygier her th	Cor	17 Fabrus Nova (First Middle Los	4	Compu	ter Software	-		
anc	d be fi	Be c	17. Father's Name (First, Middle, Las Robert A. Dickso				ther's Name <i>(First, Midd</i> Nona Plattn		ame)
J.	should nd Me mark	င္	19a. Informant's Name/Relationship		19b. Mailir	g Address (Street and Num			m. State. Zip Code)
	and 2 alth a 27 ts		Roberta D. Nail	(Sister)		Campus Lakes			
altimore,	ges 1 and the Helph III item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 [		Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date	20c. Location	n - City or Town, State
Ē	t. Pages rtment of i rtent: if ite		4 Donation 5 Other (Spec.	ity) M		ematory	11-10-2007		
Ba	Departi Departi impo any ir		21. Signature of Funeral Service Lice	dma_Moios	50 W 5	Name and Address of Fac itzke Funera 555 Twin Kno	llyHomes, In lls Road C	c. olumbia,	, MD 21045
10			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the dea , one cause on each line.	ath. Do not ente	er the mode of dying, such a	as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pocu ~  Due to (or as a conse	-con; [				Onset and Death
	Examiner		1	Due to (or as a conse	equence of):				41
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	equence of):				- Car
10	nd nd transit	Examiner	that initiated events	c. 4/p	Fract	un clas	e to	1=9 11	Yel
Ď.	oe execien a		resulting in death) Last	Due to (of as a conse	equence of):		n	O a Octivi	Y days
68760,	ficate be executed physicien and is the buriat-transit	edicai	•	Ld			ESTIFICATION APPROVED	BY MEDICAL EXA	MINER Years
ROX	leath certifics attending pl		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy		· IIII III III III III III III III III		Date of delivery
Ď.	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month Day Year
ທົ່ ລັ	as tha	oy P	Part II. Other significant conditions					d tobacco use co	entribute to the cause of death?
or d	w requires been signs should be	ted	Post PE	Hypert	2-5,0	2 6 5 6	1/201/ 15	Ses 2 □ No	3 Probably 4 Unknown
Kecords,	a law r has be e 2 sh	Completed					24a. W	topsy	Were autopsy findings available prior to completion of cause of
_	(0							rformed?	death? 1 ☐ Yes 2 ☐ No
VItal	Physician; this certific ral director,	o Be	25. Was case referred to medical examiner?  1	Hospital:	7500	Other	ce of Death (Check on)		
	g Phya er this eral di	<b>⊢</b> ⊦	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	Nursing Home 5 Re	e how injury occu	
0	Attanding In death.	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	UNKNO	14 4 - 05	BNO PL	hour	End
UNISION	r Atta	Certification:	Suicide 6 □ Could not to determined     determined		home, farm, stre		28f. Location City or 1	(Street and Nun Town, State)	mber or Aural Route Number, 2756 Autumn Clumbia MD
_				Hone			Splen	devidor. E	olumbia MD
	호수들을	Medicai	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, death ration and/or inv	occurred at the time, date a estigation, in my opinion, de	and place, and due to th	a cause(s) and r	manner as stated
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	- 1		29c. License number	1	29d. Date sign	ned (Month, Day, Year)
	- 3 - 0 · 1		1 //- /-					11/	
	6 48 4		1 LAC	· cla -		058	772	j.	-/200 >
	12		30. Name and address of person who			Print)			-/2003
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		30. Name and address of person who has the St. St. St. Date filed (Month, Day, Year)		Lun	Print)			( M/D 21075-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3615 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 12:60 PM avis NOU W 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner are 10WSan Nanor OUSOV trinore Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) 1 M 2 □ F Months Days Hours Min. 214-26-2526 Director HPriL Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov must be notified at 1 es 2 No Md. **Funeral Director** timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 21216 ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nature." Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Nidowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NELDER NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jans ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beeto, ma nita m. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Neurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) armel 21. Signature of Fundamervice Licen 22. Name and Address of Facility md, 2122 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner +ncomplete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Lue to (or as a consequence of) ndrome ntral CORD requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) P.O. ed by the a detached f 9 Unknown te has I een signed by age 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Chronic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 2 No certific director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manger of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation spital or Attendi ours after death. neral Director; A filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/07 ysade Do 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Timonium Road Suite 209 atherine Sade Dio 20 32 Registrar's Signatur 31. Date filed (Month, Day, Year) State NOV 1 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>07</u> Month **Physician** Donald B. Dixon 0:30a. Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Ellicott City 10070 Carillon Drive 8. Date of Birth (Month, Day, Year 6/21/1933 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 X M 2 □ F MD. 74 Director 213-30-0989 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2☐No Director MD. Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 1 and 2 should be filed within 72 hours after death with. Health and Mental Hygiene. 10070 Carillon Drive 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No
If Yes, Give
Year or Dates: 62-83 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: African American þ 3 ☐ Widowed 4 ☐ Divorced Completed or than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Government Information Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William B. Dixon Hilda Francis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Carolyn T. Dixon, wife 10070 Carillon Drive, Ellicott City, Md. 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 1/15/2008 Arlington, Va. 4 Donation 5 Dother (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke FH of Catonsville, Inc., 1630 Edmondson Avenue, Catonsville, Md. 21228 21. Signature of Funeral Service Licensee remmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancretic /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Early underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tra Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I or Vital Records, ò 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 page this certificate 1 Yes 2 No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division or Attending 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide after Hospital within 24 hours a 29a. Certifier 1 🏂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

(Check only one)

DaNIELLE

31. Date filed (Month, Day,

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN

3 2007

Year)

DHMH 17 Rev 1/2001

MD 6365

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

064395

29d. Date signed (Month, Day, Year)

Charles ST, Satter 209 Baltimore und 21204

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Elaine G. Dieringer 1 = 45pM 2007 NOU 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Aques Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 219-03-2545 88 Aug. 1, 1919 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No na Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Nottingham Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 Yes 2 10 16 Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Specify 3 □Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary State of Md 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Gary Evelvn Gonce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl J. Dieringer, husband 720 Nottingham Rd., Baltimore, Md. 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veter. 4 ☐ Donation 5 ☐ Other (Specify) 11/13/07 | Owings Mills, Md. 22. Name and Address of FacilitySterling Ashton Schwah Witzke FH 1630 Edmondson Ave., Catonsville, Md. 21. Signature of Funeral Service License Lemmer 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration pneumomia 12 days Due to r as a consequence of): acute rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

be l

ns 23a must b

"natural", or Item

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "nature any injury or other traumatic event, the Medical once.

Director

Funeral

9

Completed

Be

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MD.

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Physician/Medical þ Completed

Be

Certification:

cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran certificate has funeral director, After this hours after death filled in by the

P.O.

Records,

Division or Vital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 ☐ Other (specify)

Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Parkinsonism Dementica

24a. Was an autopsy perforn 2. No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

29a. Certifier (Check only one) 5 Pending investigation

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D58571

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo Cymn Tao 31. Date filed (Month, Day, Year)

900 Caton 32. Registrar's Signature

Avenue Baltimore mb

State Registrar

within 24 hours at To the Funeral D

_			1 - For State Registrar		State C	n waryian	-	rtificate of	Death		giene _{Reg. No.} 2 (	007	36161
	Physici	an	1. Decedent's Name (First		,					2. Date of De Month	Day 1	Year	3. Time of Death
	/Medi	cal	Helen C.  4a. Facility Name (If not in			imher)		4h City Town o	r Location of Death	Nov. 9	, 2007 4c. County	of Death	12:38 pm ^M
	Examir	ier	Gilchrist	_		mbor)		Towson			1	ltimo	
	Funeral Director		5. Social Security Numbe 220–12–583	4	ex □M 2∏xF	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 3	th y, Year)		place (State or Foreign
7	and w		Usual Residence of Dece 10a. State 10b.	County		10c. Cit	v. Town or Lo	cation				1.	10d. Inside City Limits
	Maryla	tor		Baltim	ore		undalk						1 ☐ Yes 2 X No
2	th the	irec	10e. Street and Number					10f. Zip Code			10g. Citizen of V	What Cour	ntry?
Hele	23a cust b	ral	103 C	enter	Place A	Apt 229		21222			USA		
1/e, H	be filed within 72 hours after death with the Maryland trail Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral Director	11. Marital Status  1 □ Never Married 2  3 □ Widowed 4 □ [		12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2 <b>∑X</b> No ive		1 ☐ Yes 2 💹 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:		. 14. Rac Blac Specify	k, White,	can Indian, etc. Hite
2/11	"natu	lete	15. [ (Specify on	Decedent's Ed Bly highest gra	ucation de completed)		16a. Deced	lent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind of Bu	ısiness/In	dustry
25	within 72 iene.  than "nai he Medica"	Completed	Elementary/Secondary 8 yrs.	(0-12)	College (	1-4or 5+)	ine. i	Housewif	_			Home	
	il Hygie other	Be C	17. Father's Name (First,	Middle, Last)				HOUSEWII	18. Mother's Name	(First, Middle,	Maiden Surnan		
<u>lar</u>	2 should be filed and Mental Hygi Is marked other aumatic event, ti	To B	James	White					Esther	Egebe:	rg		
Maryland	nd 2 salth ar 27 is r trau		19a. Informant's Name/P Wendell D		^{Type. Print)} husbar	nd			and Number or Run Place Dun			State, Zip	Code)
Baltimore			20a. Method of Dispositio 1 □ Burial 2 XCre 4 □ Donation 5 □	mation 3  Other (Specify	)		yview (	sition (Name of natory or other place Crematory	20	07	20c. Location - Baltin	•	own, State
Bal	permit. Pag Department Important: I any injury o		21 Signature Funeral	me	h				ss of Facility Funeral Ho ers Point				
	Physician /Medical		23a. Part . Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or comp ure. List only	a/	PARKI	KSON.	er the mode of dying $S$		or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner			ns,	b	(or as a conseq							0
W	uted d ansit	Examiner	Sequentially list condition if any, leading to immedia cause. Enier underlying Cause (Disease or injury that initiated events	ate	Due to	(or as a consequ	uence or):						
68760.	ificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	l	Due to	(or as a consequ	uence of):						
P.O. Box 6		Physician/Med	IF FEMALE; 23b. Was decedent preg in the past 12 montl 1 □ Yes 2 □ No 9 □ Unknown		1□Live I	tcome pf pregna birth 2 □ Feta nant at time of d own	il death 3□	Ectopic pregnancy	1			te of delive	ery Day Year
rds. P	w requires that been signed b	by	Part II. Other significant	conditions o	ontributing to d	eath but not resu	ulting in the ur	nderlying cause give	en in Part I.		obacco use cont ∕es 2  No		he cause of death?
Division or Vital Records.	siclan: The law requ certificate has been irector, page 2 shoul	Completed								24a. Was autor perfo	rmed?	Were auto prior to co death? I ∐Yes	opsy findings available impletion of cause of
Vits	Physiclan: r this certificaral director, p	Be	25. Was case referred to examiner?	medical	Hospital:			Oth	26. Place of Death	AV. 10			11 - 0
ō	Physer this eral dir	1: To	1 ☐ Yes 2 No 27. Manner of Death		28a. Date	Inpatient 2  of Injury	28b. Time of		4 🗆 Nursing Ho		dence 6 to the	er <i>(Specif</i> red	Y) HOSPICE
ion	Attending r death. ector: Afte by the fune	atior	1 atural 5 2 Accident	Pending investigation		th, Day Year)	Injury		k̂? Yes 2 □ No		,,		
Divis	al or Atte s after des il Directo	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place build	e of injury - At ho ing, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (\$ City or Tox	Street and Numb vn, State)	er or Rura	al Route Number,
	To the Hospital or Attending Phwithin 24 hours after death, To the Funeral Director: After th completely filled in by the funeral	Medical (							me, date and place, opinion, death occur				
	To the H within 24 To the Fi complete	Me	29b. Signature and title o	f certifier	7	$\overline{}$		29c. License	e number		29d. Date signer	d (Month,	Day, Year)
	,		1	20	///	)/ 2		Do	64395		NOVEMB	ER	7,2004
	5		29b. Signature and title or  30. Name and address of  DANIEUE C  31. Date filed (Month, Da	person who	completed caus	se of death (Item	23a) (Type,	Print)	2- 00,00	200	B.10-	inc	11021200
	Sta	te	31. Date filed (Month, Da	y, Year)	32.	egistrar's Signa	(U) /V (	MINKLOS	J/ 1 8W1/E	204	OHC/M	I TOT!	Ne since of
	Registr		NOV	1 3 20	07	Best 1	8 Ag	ers.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:49 PM C Mildred Dohler November 9 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford 3517 Clayton Road Joppa 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y April 12 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1□ M 2□ F 1922 North Carolina 246 24 5767 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the M-dical Examiner must be notified at 1 ☐ Yes 2¥ No Baltimore Baltimore County Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21237 USA 9144 Lennings Lane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Cleaner House Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nancy Ann Peacock Joseph Daniel Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3517 Clayton Road Joppa, Maryland 21085 Millie Parlett (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns. Nov. 13 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify e of Funeral ServiceLi 22. Name and Address of Facility
Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** lung cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 (No Month Day Year 4☐Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♠ No has the funeral director, page 2 autopsy performed? certificate 2**X** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Statemence 6 Other (Specify) Hospital: 2[0(No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR (A VANIK M. D. 9106 Philadelp hald #304 Baltimore, MD 21237

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Catherine DICKSON Agnes /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL GLEN BURNIE ANNE SAKTIMOTE WASHINGTON GENTER 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 26 1 F Director Jul 16, MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at MD Anne Arundel Millersville 1 Yes 2 No **Funeral Director** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be read in the medical Examiner must be reader. 339 Trois Court 21108 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc 1 Yes XX No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Butcher Meat Packing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pau1 Gauger Catherine Α. Schwallenberg 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Brad C. Thompson (nephew) 8348 Fairwood Ct. Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Maryland Vet. Cemetery 11/13/07 | Crownsville, MD 22. Name and Address of Facility Singleton Funeral Home 21. Signature of Funeral Service L 2nd Ave SW Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) META STATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fores a consequence off Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į. in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has 2 No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manney of Death 28d. Describe how injury occurred Injury at Work? Medical Certification: 5 Pending investigation 1 Avatural Injury n 24 hours after death.

The Funeral Director: All bletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) mi)

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Hapital

32. Registrar's Signature

trame and address of person who completed cause of death (Item 23a) (Type, Print)

501

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month 10, 2007 November George Mann Durrett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3366 Belmont Ave. Reisterstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct.11,1917 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 218–03–7015 90 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at a or 28a-f she be notifled a Director 1 □Yes 2 No MDBaltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must b 3366 Belmont Ave. USA 21136 by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/President 12 Steel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Edith Klutch Clyde Durrett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Durham, NC 27705 Douglass Durrett (son) 5905 Treetop Ridge, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify Entombment Dulaney Valley Mem. 11/13/2007 | Timonium, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Furnit Se 1050 York Rd, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA WEEKS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit requires that the death certificate be executed Due to (or as a consequence of) Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Dav Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

State

MD EBELING 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

PRIVE SUITE 100 7401 32. Registrar's Signature

se of death (Item 23a) (Type, Print)

Registrar

OSLER

State of Maryland / Department of Health and Mental Hygiene 07 36168 Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** F. 2007 9:45 A DeBouver November 8, Audrev /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Edenwald Nursing Center Baltimore Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9 / 1 4 / 1 9 2 3 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 217-18-6019 84 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2x XNo Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code with 21286 USA 800 Southerly Road apt 1301 death \ by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Itel 1 ☐ Yes 2**√**MNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 🎗 ☐ No Specify: 3√Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Hilbert Thompson Alice Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an item 27 is 9 Hemlock Ct. Hunt Valley, MD 21030 Susan Gralley/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: if ite 1 ☐ Burial 20☐0 Cremation 3 ☐ Removal from State Hilltop Serv. Corp11/10/07 ö permit. Page Department of Important: If any injury or once. Towson, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1050 York Rd 21. Signature of Funeral Service Licensee Towson MD Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kicknee Immediate Cause (Final Chronic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð des 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes the Hospital or Attending Physician: hin 24 hours after death, the Funeral Director: After this certifica 25. Was case refe ed to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Aursing Home Hospital: 2 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 -Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 2 024732 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 4 weine 21204 32. Registrar's Signatur 31. Date filed (Month, Day, Year) Speak ! State NOV 1 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #30 Per DVR G873 11/13d@ntifiBate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Joseph Thomas Dobbs /Medical November 9, 2007 4:30 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Center Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑** M 2 □ F Director 212-18-3728 88 Sept. 23,1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore Director Timonium 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21093 USA Funeral 2300 Dulaney Valley Road Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Tyes 2 ☐ fYes, Give ∕ear or Dates: 2 No Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No δ 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude F. Dobbs Emma Gertrude McAleer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Dobbs- Wife 2300 Dulaney Valley Road Baltimore, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 11/13/2007 Baltimore, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 23a. P. tt1. Finter the dise s set of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. its mily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2**K** No page ; certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 ▼ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: A in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4:30 a.m.

2007

6

NOVEMBER

JOSEPH DOBBS

Registrar DHMH 17 Rev 1/2001

State

10

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

NOV 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43725

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			For	State of Maryland / Depa		lental Hygier	18 0 0 7	36170
			1 - State Registrar		rtificate of Death	Reg. I	12001	30170
	Physic	ian	1. Decedent's Name (First, Middle, Last	511:-14			Day Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give	atract and number)	Ab City Town and posting of Booth	NOVEMBER	3	7 @2:12F™
1	Examir	1er		Medical Center	4b. City, Town, or Location of Death		4c. County of Death Balt	cimore
-	Funeral	7	Social Security Number 6. Se		If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign
н	Director		216-16-8820	M 200 F 88 Yrs.	Months Days Hours Min.	(Month, Day, Yea		yland
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			0d. Inside City Limits
	Maryl f sho	ţo	md Balt	imore T	01.1500			1 □ Yes 2 <b>⊠</b> No
	r 28a	Director	10e. Street and Number	1171010	10f. Zip Code	10g. (	Citizen of What Coun	ntry?
	th with	a D	509 E. Jopp	2 Road	212810		USA	
	r dea tems er mi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MaNo	1 ☐ Yes 2 No Specify:		Specify:	10
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed k	15. Decedent's Edu	ucation 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Inc	dustry
215	hin 7% e. an "na Media	Completed	(Specify only highest grade Elementary/Secondary (0-12)	(Give life, I	kind of work done during most of work DO NOT use retired)	ing		,
	filed withi Hygiene. other thar	Sol	12		me maker			me
pu	be file	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maid	en Surname)	
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, ti	٩	19a. Informant's Name/Relationship (Ti	Elliott	Zdn	a 1500-	<u>th</u>	
Ma	d 2 sl th an 7 is r traur		12:11 - V	0. 1/22-	ng Address (Street and Number or Rui	1 /	1	Code)
	ges 1 and 2 t of Health If item 27 i or other tra	-	20a. Method of Disposition	20b. Place of Dispo	Uakleigh Koac Disition (Name of		Location - City or To	own, State
E O	00		1  Burial 2  □ Cremation 3  □ F 4 □ Donation 5  □ Other (Specify)	more our	d memorial 11/12	1/2007 12	altimore	md
Baltimore,	- t # =		21. Signature of Funeral Service Licens	11000	2. Name and Address of Facility Change Fune ray Change	001 505	SI	s-Propoille
m	permi Depar Impol any Ir		Stacie 2	martin 3	800 Harford Roac	Parkuil	le md 2	1234
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do not entine cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
M	Physician		Immediate Cause (Final disease or condition	. HYPOVOLEMIC SH	HOCK			Onset and Death HOURS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	5 T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			222 AND 2 6 AND
		e.		b. RESPIRATORY FF	11LUKE			DAYS
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. ACUTE RENAL IN	ICHEETOTENOV			HOURS
oʻ	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as a consequence of):	ASOLLICIENCI			UUUUS
8760,	tate be executed thysician and the burial-transit	dical		CORONRAY ARTER	RY DISEASE			YEARS
9	ertifica ing ph e as t	Med	IF FEMALE:					
Box	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of deliver	ery Day Year
P.O.	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time of death 5□ 9□Unknown	Other (specify)			•
	res that igned by be detar		Part il. Other significant conditions co	ntributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to th	ne cause of death?
Records,	quires in sign	d by				1 ☐ Yes	2⊠ No 3 □ Prob	ably 4 Unknown
တ္တ	aw requir is been si 2 should	Completed				24a. Was an	24b. Were auto	psy findings available mpletion of cause of
Ä		mo:				autopsy performed? 1□ Yes 2⊠1	?   death?	mpletion of cause of 2□ No
Vital	Physician: The this certificate ral director, pag	Be C	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)		
or/	Physic this c	မ	1 ☐ Yes 2 ☑ No	Hospital: 1 ■ Inpatient 2 □ ER/Outpatien		me 5 Residence	(-)	y)
no	ing Affer une	ion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division	f or Attending after death. Director: After I in by the fune	ficat	3 Suicide 6 Could not be	28e. Place of injury - At home, farm, stro		28f. Location (Street	and Number or Rura	al Route Number.
Ö	afor A s after Il Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		City or Town, Sta	ate)	,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in E			sician: To the best of my knowledge, death iner: On the basis of examination and/or in				
	the H hin 24 the F nplete	Medical	one)	and manner stated.				
	Vit Cor	~	29b. Signature and title of certifier		29c. License number	29d. L	Date signed (Month, )	Day, Year)
			1 ( buy)	'/	D63974	/	1/12/07	
	1			ompleted cause of death (Item 23a) (Type,		MATERIAL CONTRACTOR	I man a man a	
	Sta	te	IMRAN SIDDIQI. 31. Date filed (Month, Day, Year)	M.D. /6V1 U51 Eh	P DRIVE TOWSON,	PHRYLHN	U ELEVIA	
	Registr	ar	NOV 1 3 2007	32. Registrar's Signature				

DHMH 17 Rev 1/2001

		For State Registrar	State of Ma	aryland		artmer r <i>tificat</i>			nd Me	-	giene Reg. Na	000	77	36	171
		Decedent's Name (First, Middle,	Last)						2	. Date of De	ath		21	3. Time	of Death
Physici /Medic		Doris Jean Edi	vards						N	Month ovembe	er 9	, 200	Year 07	9:	00 A ^M
Examin		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or	Location of E	Death		40	c. County			
		Calvert Manor Nu		- // (	4 h :- 4h 1 1	R If Unde		Sun If Under 24	Hm I o	Data of Dia	41.	Ce	ecil	(O4+4	
Funeral Director	7		. Sex 7. Age 1	82	ast birthday) Yrs.	Months	Days		Min.	. Date of Bir (Month, Da Jan。 5	y, Year	025	Coun	iace (Siai try) Ylane	e or Foreign
S 46		220-22-0264 Usual Residence of Decedent		82						Jall. L	) , <u>1</u>	525	LIOT	утан	u
ryland how		10a. State 10b. County		10c. City	, Town or Lo	cation							1		City Limits
e Ma Sa-f s	Director	Maryland Ha	erford		Abe	erdee									es 2 🛣 No
vith the or 2	Dire	10e. Street and Number				10f. Zip					10g. Ci	itizen of W	/hat Coun	try?	
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fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 🗚					panic Origin n, Mexican, F	Puerto Ri	can, etc.)			k, White,		
al'; o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2IX No	Specify:				Specify.	Whi	te	
72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usu kind of wo	al Occupa	tion uring most of	of working		16b. h	Kind of Bu	siness/Ind	dustry	
Atthin ne.	ld m	Elementary/Secondary (0-12)	College (1-4or 5	i+)				J				Oram	Home		
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. Adother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, La	est)		п	omema		18. Mother's	Name (	First. Middle	. Maide				
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and 2 alth a 127 is		Baron Edwards /	Son		612	High	Pla	in Dr.	, Be	l Air	, MD	210	14		
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Pag tment tant: l		4 ☐ Donation 5 ☐ Other (Spe	cify)	Hil	ltop S				1-14	-07	Tow	son,	Mary	/land	
permit. Pages 1 and 2 should by Deprmit. Pages 1 and 2 should by Department of Health and Menta Important: If them 27 is marked any injury or other traumatic edonce.		21. Signature of Fundal Service Li	ensee			2. Name a: McCOM 1317	nd Addres Ias Fi Cokes	s of Facility ineral sbury	Hom	e, P. <i>A</i>	A. gdon	, MD	2100	)9	
		23a. Part1. Enter the disease, or or shock, or heart failure. List or	mak at wis that caused	I the death										Approxim Interval E	Between
Physician		Immediate Cause (Final disease or condition	_a. Con	gesti	ve he	art	fail	ure						Onset an	
/Medical Examiner		resulting in death)	Due to (or as			\ i								4	
£ 2 2 4	<u>5</u>	Sequentially list conditions,	b. Due to (or as		Fibril	141100							-	1 he	eks
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death certifical attending plant of the use as t		IF FEMALE:	00- 15	-6										-0.00	
attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes ► No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	Ideath 3	⊒Ectopic p ⊒ Other (s						23d. Dat Mo	e of delive nth	ery Day	Year
the d	ysic	1  Yes  No 9  Unknown	9□Unknown	tillie of de	bain or	_ Other (S	occity)								
s that	by Pr	Part II. Other significant condition	s contributing to death be	ut not resu	ılting in the u	nderlying (	cause give	n in Part I.		23e. Did 1	tobacco	use contr	ribute to tl	ne cause o	of death?
quire:									_	1 🗆	Yes	No.	3 ☐ Prob	ably 4	Unknown
law re as bee 2 sho	plet								_	24a. Was				psy finding	gs available
The ate has page	Completed										ormed?	6	death?	2□No	. 00.000
cian: ertifica	Be C	25. Was case referred to medical examiner?							f Death (	Check only	one)				
this c	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier			Nursi		5 ☐ Resi				y)	
Jing P	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Day		28b. Time o Injury	" м	28c. Injury Work 1 □ \	at ? ′es 2∐No		d. Describe	now inje	ury occurr	ea		
Attend death ctor: y the	ficat	2 Accident investiga 3 Suicide 6 Could no	be 28e. Place of inju	ury - At họ	me, farm, str					f. Location (			er or Rura	i Route N	umber,
after Dire d in b	Certification:	4 ☐ Homicide determin	building, et	c." (Specify	1)					City or To	wn, Sta	te)			
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C		Physician: To the best caminer: On the basis o and manner sta	f examinat											e(s)
omple	Mec	29b. Signature and title of certifier	2 0				c. License				29d. D	ate signe	d (Month,	Day, Year	7)
F 5 F 0		> people!	rule				0000	48053	$\supset$		(1	11010	7		
	1	30. Name and address of person w	no completed cause of d	eath (Item	23a) (Type,	Print)	Δ.	\	Mr	210	01				
8		Pashant 5hukla	m.D. 155.P.	acke S	Treet 1	F400	1490	cen	V * * 1	210	)				
Sta Registr	_	31. Date filed (Month, Day, Year)**	32. Sgletr	ar's Signa	ture	mark.	8								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 36172

mara Elarca		- For State	Certificate of	of Death	ia momai	Rec	2 U U	1 3011
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death Month	Day Year	3. Time of Death
edical Exami		Richard Eldred				November	8, 2007	0841 hrs
		4a. Facility Name (if not institution, give street and number	er)	4b. City, Town, o Glen Burni		eath	4c. County of Death Anne Arundel	'
		Baltimore Washington Medical Center	Age (In yrs. last birthday)	If Under 1 Ye		1Hrs 8 Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director				Months Day		Min. JAN 31	Foreig	n untry) <b>MT</b>
Director		364-74-7359 1XM 2 F	45 Y	rs.		JAN 31	1902	MIL.
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
10 W 20		MD Anne Arundel	Glen Burn	nie				1 Yes 2 X No
ryland ra-f sh	휭	10e. Street and Number	Olen Barr	10f. Zip Code		10	g. Citizen of What Cou	ntry?
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f short rannatic event, the Medical Examiner must be notified at once	Director	7894 Covington Avenue		21061			USA	
with the s 23a c noti		11. Marital Status 12. Was Decede		Vas Decedent of H	ispanic Origin?	( Specify Yes or No-	14. Race - Amer	ican Indian, Black,
leath r	Funeral	1 Never Married 2 X Married Armed Force	es? If	Yes, specify Cuba	an, Mexican, Pu	uerto Rican, etc.)	White, etc.	
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	81-01	Yes 2 X N				White
ours a		15. Decedent's Education (Specify only highest grade of	during	ent's Usual Occup most of working lif			16b. Kind of Business/	Industry
6 n 72 h ical E	ě	Elementary/Secondary (0-12) College (1-4 o		. mrz. Amolie	rat		U.S. Airf	oran
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at Hyger of the	Be C	Wayne Eldred			Caro	l Carpen	iter	
212 uld be Ment mark	0	19a. Informant's Name/Relationship (Type, Print )	19b. Mail	ing Address (Stre			ber, City or Town, State	e, Zip Code)
4D 2 sho h and 27 is	-	Kelly J. Eldred - wife				Glen Burn		
Baltimore, MD 21215-0036  pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b. Place of Disp crematory or	osition (Name of co	emetery,	Date	20c. Location - City o	r Town, State
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altir mit. I partm porta ury o		21. Signature of Funeral Service Licensee  Steven H. Will	22	Name and Addre	ss of Facility			-
E P P E	1.0	* NILW		299 Frede	rick R	ty of Mary oad, Balti	more, MD	21228
Physician		23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line.	ed the death. Do not ente	r the mode of dyin	g, such as card	liac or respiratory arre	est, shock, or neart	Approximate Interval Between Onset and Death
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o. B the de cy the	Physician/	Part II. Other significant conditions contributing to de	_	e underlying cause	e given in Part	I. 23e. Did to	obacco use contribute t	o the cause of death?
(ecords, P.O. B The law requires that the d ate has been signed by the age 2 should be detached	<u>ج</u>						2 No 3 Pr	obably 4 Unknown
ds, equire	Completed			<u>-</u>		24a. Was		autopsy findings available completion of cause of
of Vital Records, g. Physician: The law requir After this certificate has been s meral director, page 2 should I	ם						rmed? death?	
		25. Was case referred to medical		26.Pla	ce of Death (C		2	
Vital ysician: his certif director,	o Be	examiner? Hospital:	atient 2 ✓ ER/Outpation	ent 3 DOA	Other 1	Nursing Home 5	Residence 6 Oth	er:
n of Virting Physical After this funeral dir	⊢:	1 Yes 2 No 27. Manner of Death 28a. Date of Manner of Death	Injury 28b. Time	of Injury 28c. Ir	njury at Work?	28d. Describe	how injury accurred	
	ţi	1 X Natural 5 Pending (Month, Da	ау, теаг)	1	Yes 2 N	lo		
Division of Vital Ista or Attending Physician: rs after death.  al Director: After this certification by the funeral director.	lig	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of	of Injury - At home, farm, s	treet, factory, office	e building, etc.	28f. Location ( or Town, S		Rural Route Number, City
Divi	Certification:	4 Homicide determined (Specify)						
Hos 24 h Fun etely		29a. Certifier (Check only) 1 Certifying Physician: To the best of	f my knowledge, death oc	curred at the time,	date and place	e, and due to the caus	se(s) and manner as st	ated. the cause(s)
To the vithin To the comple	Medical	one) 2 Medical Examiner: On the basis of and manner state	examination and/or investi ed			at the time, date	29d. Date signed (N	
->-	Ž	29b. Signature and title of certifier			ense number		November 9, 2	
2 1		Doma Mudimentimi			C.M.E. 		November 9, 2	
Keno		30. Name and address of person who completed cause		11 Penn Stre	et Baltimor	e. MD 21201		
OKY			etrar's Signature	ver i				
S Pagis	tate	31. Date filed (Month, Day, Year) 32. Regi	strat's Signature	Sec. 63 0				

ORIGINAL

OCME

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5 7 2007 5:42 AM November /Medical 4a. Fecility Name (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Ctr **Baltimore** Towson
It Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. Days Hours 1 M 2 F Director MONE 11/07/07 Maryland Usuat Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21133 USA 9601 Orpin Road, #203 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: þ Unknown 3 Widowed 4 Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kyle Edwards Lynette Jasper Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **STUAC** TATMOLOGY Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08 IMOre 2007 * 4 □ Donation - Jenions tBONS CO. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee OSAKO MONKTON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Serve Prematurite **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit or Attending Physician: The law requires that the death certificate be executed Box 68760,72 that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy be detached for Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2√2 No 24a. Was an autopsy performed? certificate 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred 27. Manner of Death 1 🔀 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident completely filled in by the 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury : At home, tarm, street, tactory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26112 11-7-2007 Junga noima 30. Name and address of person who completed cause of death (fem 23a) (Type, Print) Norma V. Gungon, M.D. 6565 N. Charles Street, Baltimore, Maryland, 21204 31. Date filed (Month, Day, Year) State Registrar NOV1 3 2007

DHMH 17 Rev 1/2001

		1	For State Registrar		State	of Mar	yland		irtmen <i>tificate</i>			and M	lental Hy	giene Reg. N	007	36174
Ph	ysicia	_	1. Decedent's Name (Fi		_{st)} gerton								2. Date of Dea Month November		7 Year	3. Time of Death 11:00 A M
	nedic amin		4a. Facility Name (If not 9943 Perine	institution, giv		ımber)					Location o			4c. C	ounty of Deat	h
Fun Dire			5. Social Security Numb 220 07 2748		Sex 1 □ M 2√□ F	7. Age (	'In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da OCTODET	h 25°4192	9. Birt Balt	hplace (State or Foreign Indire ,Maryland
aryland •how	ii ii	70		cedent b. County a <b>ltimore</b>				Town or Lo								10d. Inside City Limits
with the M	L'he notifie	Funeral Director	10e. Street and Number 9943 Perine L	ŗ					10f. Zip	Code 1234				10g. Citize	on of What Co	ountry?
(1 Z 1 3-UU3D within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28e-f ehow	Xacciner mus	by Funera	11. Marital Status  1 Never Married  3 Widowed 4		12. Was Dec Armed F 1 Tes If Yes, G Year or	orces? 2 <b>X</b> ∑No iive			Was Deced f Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		I. Race - Ame Black, Whit Specify:	
1 Z 1 5-UC within 72 hou ane. then "natura	a Madical E	Completed	(Specify of Elementary/Seconda		ade completed	(1-4or 5+)		16a. Deced (Give life. I	kind of wo DO NOT us	rk done a se retired,	luring mos )	at of work	ing		of Business	Industry ton Greenhouse
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. 27 ie marked other then "natural", or	tic event, II	To Be Co	17. Father's Name (First Allen Brice	st, Middle, Las	")						18. Mothe		e (First, Middle, Dinsmore			
	or other trauma		19a. Informant's Name  Richard C  20a. Method of Disposi  1X Burial 2 □ C	Egerton tion remation 3	⊒Removal from	n State		9944 I ce of Dispo	Perine sition (Nar	Lane ne of other place	Bal	timor	e Maryla Date	20c. Loc	234 ation - City or	Town, State
Baltimore, permit. Pages 1 a Department of Hee Important: If Item	any injury once.		4 Donation 5 D			<b>V</b>	More	22	2. Name ar BSSANN	d Addres Fune:	ral Ho	ime In			nore,Mar 21236	y Land
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/Med Exam	iner	er	Sequentially list condit if any, leading to imme cause. Enter Underlying	ions,	_{b.} and l	31adc	conseque CONSEQUE									
ate be executed hysicien and	burial-transit	cai Examiner	cause. Enter Underlyii Cause (Disease or inju that initiated events resulting in death) Last	ry		o (or as a	conseque	ence of): .latio	n							
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I RECORDS, P.O. BOX 58 The law requires that the death certifica ate has been signed by the attending of	be detached for use as the	by Physician/Med	IF FEMALE:  23b. Was decedent proint the past 12 mo 1 ☐ Yes 2 ☒ N 9 ☐ Unknown	nths?		birth 2 gnant at ti	f pregnan Fetal of me of dea	death 3	∃Ectopic p ∃Other (sµ					2:	3d. Date of de Month	livery Day Year
rdS, P. quires that a n signed by	uld be deta	ed by Ph	Part II. Other significa Heart Fai		contributing to	death but	Art	hriti		ause give	en in Part	l.		obacco us Yes 2		o the cause of death?
VITAI RECOLD sicien: The law requir certificate has been si	page 2 should t	Completed	Cachexia				GEF	RD					24a. Was auto perfe 1 Yes		24b. Were a prior to death?	utopsy findings available completion of cause of s 2  No
Of VIta Physicien: this certific	rector,	Be	25. Was case referred examiner?		Hospital:					Oth	00		th (Check only		(Tour - / 2 -	
DIVISION Of VITal Hec To the Hospitel or Attending Physicien: The law within 24 hours after death.	e funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident	5 Pending investigate	28a. Dat (Mc	∃Inpatien e of Injury onth, Day		R/Outpatie 28b. Time o Injury		28c. Injun Work	4 11	lursing He	28d. Describe		Other (Sp	9CIIy)
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DIN the Hospitel or in 24 hours after the Funeral Din	pletely fill	edical	(Check only 2[ one)	Medical Ex		he best of basis of anner stat	examinati	vledge, deat on and/or in	nvestigation	n, in my o	pinion, de	nd place, ath occur	and due to the red at the time	, date and	place, and du	e to the cause(s)
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R	Sta egisti		N.	1V 1 3	2007	gistra GLAS	Joignal	1 A	anti)			<u>-</u>			-	

		-	For State Registrar	State of Maryland		artment of H			giene	007	36175	
			Decedent's Name (First, Middle, Last	st)		2. Date of Death 3. Time of Death						
	Physicia		TIMOTHY	EISENHOUR NOVEMBER 7 2007 0433 M								
	Aa. Facility Name (If not institution, give street and number)  THE JUHNS HOPKINS HOSPITAL						Location of Death	County of Deat	n			
							MORE C		N/A			
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la:		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)		nplace (State or Foreign untry)	
	Director		194-50-2597	× 43	Yrs.					64 Penn	sylvania	
	and *	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits	
	Aaryli eho	5	MD Anne A	rundel	Odent	on					1.□Yes 2□No	
	28a-	Director	10e. Street and Number		-	10f. Zip Code			10g. Citiz	en of What Co	untry?	
	Sa or		259 St. Michael's	Cirolo		211	1 2		USA			
	ne 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No		4. Race - Ame		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Explainar must be notified at angle.	by Fur	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 21☑ No	o Rican, etc.)	Black, White, etc.  Specify: White				
Ö	2 hou	bed	15. Decedent's E	ducation		dent's Usual Occup		16b. Kind of Business/Industry				
7	in 7	Completed	(Specify only highest gra		College (1-4or 5+)			king	Food			
2	d with	Eo	Liementary/Secondary (0-12)	2	Man	ager			FOC	<b>J</b> u		
ק	oth oth	BeC	17. Father's Name (First, Middle, Last				18. Mother's Nan	ne (First, Middle,	Maiden S	Surname)		
<u>lai</u>	uld b Ment Ment rrked rtfc e	2	Unobtainable				Barbar	a Humme	r			
an	2 sho and I		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	iral Route Numbe	er, City or	Town, State, 2	Zip Code)	
Σ.	and salth n 27		Maureen Eisenhou			St. Mic	hael's Ci					
ore	of Heritary		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Cel	metery, crei	osition (Name of matory or other place		Date		cation - City or		
Ĕ	Pag ment ant: I		4 Donation 5 Other (Special	y) Evar	is Eag	le Crema	tory11/16	5/07			nnsylvania	
Baltimore, Maryland 21215-0036	permit. Depertrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportrimportri		21. Signature of Funeral Service Lice	nsee	22	Name and Address Address Bela	ss of Facility M	iller-Di				
	Pnysician		23a. Part is near the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Interval Between Interval Between Interval Death									
			Immediate Cause (Final disease or condition							Onset and Death		
1	/Medical		resulting in death)	a. A CUTE MYELOGENOUS LEVKEMIA I MONTH  Due to (or as a consequence of):								
ı	Examiner			h ————————————————————————————————————								
		Je.	Sequentially list conditions, if any, leading to influedate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
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9	ing p	Mec	IF FEMALE:	02a Mura autama of grandany								
Вох	eath certific ettending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal	death 3[	Ectopic pregnanc	1	2	23d. Date of delivery  Month Day Year			
	e des	3 CI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of dea	Other (specify)			e. Did tobacco use contribute to the cause of death				
P.O.	that the de led by the e detached t	P.	Part II. Other significant conditions	contributing to death but not resul						the cause of death?		
	8 50	ģ	Parent argumount conductions	Softwaren to double out not room	g	and only ing occasio give		Yes 2 No 3 Probably 4 Unknown				
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ō	Physician: rthis certific ral director,	. To	1 Yes 2 No	1 inpatient 2 Envoutpatient 3 DOA 4 Nursing Home					e 5 Residence 6 Other (Specify)  Id. Describe how injury occurred			
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Division	F 2 F C	Certification:	4 Homicide determined	25e. Flace of injury * Actionie, fairt, street, factory, office					City or Town, State)			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	ledical C		hysician: To the best of my know miner: On the basis of examinati and manner stated.								
	To the within 2	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Dat	e signed (Mon	th, Day, Year)	
			MAGO	OCTO	R DOO	64512		NOYEMBER, 7, 2007				
7	. 7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	0		NEIL AGEARW	AL, 600 NOR	TH W	OLFE "	STREET	BALTIN	nore	, MAR	YLAND, 21287	
	Sta Regist			32. Registrar's Signat								
			1101 T 9 F00	- Jacobson Do	19							

07-08635 Lonnie Foote Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2007 36176

le Foote	1	- For State			Certificate of Death						Reg. No. 3, Time of Death				Time of Death
Divisio	_	Registrar	s Name (First, Midd	le,Last)				2.			2. Date of Death Month Day Y November 6, 2007		Year	١	1625 hrs
Physicia Sical Examin	pllington										lovember 6, 2007		Death		
		4a. Facility I	nn1e				4b. City, Town, or Location of Death					40.	. County of		
			nes Hospital					Baltimore		2411	0. Date of Pi	eth (NANA/	DDVVVV	g. Birthr	place (State or
E		_	curity Number	6. Sex	7. Age	(In yrs. last b	irthday)	If Under 1 Yea Months Day		1 die			1/		ntry) MD
Funeral Director	- 1		8-1676	1 X M 2	Je l	58	Yrs.	Months Day	110013	1	07 0	)6	49	Cour	itry) P1D
Director	- 1			I A IVI											10d. Inside City Limits
ž.	}	10a. State	lence of Decedent 10b. County	/		10c. City, Tov									Yes 2 No
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Mary 28a- d at	Director		and Number	i white a	Λ11.0			21	2 <b>1</b> 5		1		U.S.		
the land	اۃ	6007	Park He	ignes	as Decedent	Fire in II C	13 Wa	s Decedent of Hi	spanic Orig	in? (Spe	cify Yes or N	No-	14. Race	- Americ	an Indian, Black,
with with pe n	era	11. Marital	Status er Married 2		med Forces?		If Y	es, specify Cuba	n, Mexican,	, Puerto R	tican, etc.)		White		a ole
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5-0036 iled within 7. Hygiene. I other than	ပိ		s Name (First, Midd	ile, Last)					Ger	truc	de Sa	vag	e		
2121; ould be fil Mental I: marked ic event,	Be	Dan	Foote				10h Mailin	g Address (Str	eet and Nur	mber or R	ural Route N	lumber,	City or Tow	n, State	, Zip Code)
21 ould d Me s ma tic ev	ြို	19a. Infor	mant's Name/Relation	onship (Type, Pri	nt)		3112	g Address (Street	ia A	ve, E	Balti	HOL	e/ 11	u 2.	
MD nd 2 sho alth and m 27 is aumati			i Foote-	-Daugii		20b. Pla	on of Dicpo	sition (Name of o	emetery.		Date	200	c. Location	- City or	Town, State
		20a. Meth	od of Disposition rial 2 Crema	tion 3 Rer	noval from S	tate cre	matory or o	ther place)	Park	111	/13/0	7 R	anda	<b>11</b> s	twon, Md
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr	ł	1 000	nation 5 Other	Specify:		Kin	g Mei	HOLIAI	Carili						
Baltimo permit. Page Department of Important: injury or ott	Ì	21 Signa	ture of Funeral Serv	rice Licensee	1		22. M a	Name and Addre	H We	st	- 1			MA	21215
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and a fearured for use as the hurtal - transit.	Modical	₹ UI	NPENDED		Sa 27.2	28a-f no	ermF08	374 <b>,</b> 12/13	/07TT_					f al altino	
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X 6 h cer	acn i		es 2 No 9	Unknown a	Unknown	at time of dea	5	Other (Specify)				-			
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c law		Completed by									1.55	Yes 2	No	1 🗸	Yes 2 No
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of Ving Physical After this		27 Mar	Yes 2 No		28a. Date of (Month, D	Injury	28b. Time		. Injury at W	-	1				
ding h. Aft	Į į	5 1	Natural 5	Pending	10/22/	2007	5:51 1	nm l	Yes 2	21	subj	ect a	assault	<u>ed</u>	Dural Doute Number Cit
SiO Vtten deat	y the	2	Accident	Investigation	28e. Place	of Injury - At h	ome, farm,	street, factory, of	fice building	g, etc.	28f. Loca	ation (Str own, Sta	reet and Nu ate)	mber or	Rural Route Number, Cit
lor / after	ii.	Certification:	Suicide 6	Could not be determined	(Spacify)	Store	2								altimore, MD
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	completely filled in by the funeral	4 X 29a. C	Homicide	ing Physician:				ccurred at the tir	ne, date an	d place, a	ind due to th	e cause	(s) and mar	iner as s	stated.
n 24 h	letely	(Check	only 1 Certify	at Examiner: On	the basis of	examination a	and/or inves	ccurred at the tire tigation, in my of	oinion, deat	h occurre	d at the time				
To th withi	com	ㅎ	gnature and title of	and	d manner sta	ited.		29c. L	icense num	nber		1	29d. Date :	signeu (	(MOTHII, Day, rear)
		≥ 29b. S	gnature and die or		10 1	200		(	D.C.M.E.			- 1	Novemb	er 7,	2007
			Meliner	Busk	11	10	m 23a)								
2			me and address of		pleted cause	e of death (Ite lical Exam	m 238) iner = 11	11 Penn Stre	et, Baltin	nore, N	1D 21201				
6			elissa Brassell		200	gistrar's Signa									
		200	te filed (Month, Day	Year) 2007	R.o.	gistral s Signa	A	all!							
Re	gist	rar	1277.		-		ORIG	INAL							
	. 4 10.	204	ſ	CME			UKIG	11477							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Mary Myrtle Flowers vovember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Sept. 25, 1915 (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F Maryland 216-16-4555 92 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 10a. State 1 ☐ Yes 2 ☐ Nio Baltimore MD Director Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or adical Examiner must be 809 Eastern Avenue 21221 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No White Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Hairdresser 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be George Fitch Kuniqunde Miller ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary E. Gephardt 809 Eastern Avenue Baltimore MD 21221 permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory /1 13 07 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Colit Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest. ations that caused the Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2**1** No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe this certificate 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: After t 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

9000

Franklin Square Drive Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lambi

327 Registrar's Signature

Monya

2007

-nocent

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 8:01р м 2007 F. Forbes Nov. 11 Mary 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 25 A Cedar Drive Middle River Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, April Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Days Months 1 □ M 2 🗙 F **,**1935 217-46-0446 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State MD Baltimore 1 ☐ Yes 2€ TNo Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25 A Cedar Drive 21220 USA 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🛛 No White Specify Specify: 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Brittian Florence Bay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Randy Hayes /son 1408 Persimmon Place Forest Hill MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery 11/21/07 Baltimore MD 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral rervice Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or composhock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1∐ Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

10

items 23a

'natural", or

than

h and Mental Hygie or other traumatic event,

Department of Health ar Important: If item 27 is any injury or other trau

the Medical

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

death

Examiner must be notified

Director

Funeral

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Completed

Be

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physician s the burial þ Director: filled in by

Examiner Physician/Medical þ Be Completed Medical Certification: To To the Hospital o within 24 hours aft To the Funeral D completely filled in

29b. Signature and thie of certifie

29a. Certifier (Check only one)

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide 4 ☐ Homicide

5 Pending investigation 6 Could not be determined

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h Time of

28c. Injury at Work? Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. License number

29d. Date signed (Month, Day, Year) 13/0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1124 MACEAVE BALTZMORE MD 21201 HIVANIMOA FHIT 31. Date filed (Month, Day, Year)

Registrar

NOV 1 3 2007

32. Registrar's Signature

and manner stated.

			For Stata		State of Marylan	•		nd Men	tal Hygi	ene	7 36170			
			Ragistrar  1. Decedent's Name (First,	Middle Loot	1	Centric	ate of Death	2.5	Ra Date of Death	g. NG_ U U	3. Time of Death			
	Physici	an		Middle, Last,	,		FAIR	ı	Month	Day Y	'ear I M			
	/Medic		4a. Facility Name (If not ins	titution, aive	street and number)	4b. C	ity, Town, or Location of D		OVEMB	4c. County of				
	Examin	er	THE JOHNS		KINS HOSPIT			ATV						
Ī	Funeral Director		5. Social Security Number 213-34-343	6. Se			der 1 Year   If Under 24		Date of Birth Month, Day,	1939	Birthplace (State or Foreign Country)  Maryland			
	and		Usual Residence of Deceded 10a. State 10b. C		10c. Cit	ty, Town or Location					10d. Inside City Limits			
	ter death with the Maryland Itams 23a or 28a-f show it et must be rediffed at	tor	MD		T	nitima	00		1 ☐ Yes 2 ☐ No					
	r 28a	Directo	10e. Street and Number			10f.	Zip Code		10	g. Citizen of Wh	at Country?			
	th with	al D	626 Par	Kwo	rth Aven	sue	21218			us	A			
	r death	Funeral	11. Marital Status		12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Do	cedent of Hispanic Origin specify Cuban, Mexican, F	? (Specify Puerto Rica	Yes or No- n, etc.)		American Indian, White, etc.			
903	ਰ ਨੂੰ	by Fi	Never Married 2[ 3 ☐ Widowed 4 ☐ Div		1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □ Ye	s 2 No Specify:			Specify:	Black			
⋛	72 hours afte natural', or l	edt	15. De	cedent's Edu	cation	16a. Decedent's t	Isual Occupation		1	6b. Kind of Busi	ness/Industry			
<u>.</u>	within 72 ane. than "nal	plet	(Specify only Elementary/Secondary (	highest grad	e completed) College (1-4or 5+)	(Give kind or life. DO NO	work done during most of Tuse retired)	f working		C/				
7	d with	To Be Completed	1244			Admin	istrative A	SSIS	tout	Chey	ra			
	be file tal Hy d oth		17. Father's Name (First, N	fiddle, Last)			18. Mother's	Name (Fir	h /	laiden Sumame)				
<u>\sq</u>	Meni Meni		William	tai	R	T	Est	elle	Mcg	ruar to	rate, Zip Code)			
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Re	lationship (Ty	ipe, Print)	19b. Mailing Add	ess (Street and Number of	- 72	ute Number,	AAA A	122			
e,	s 1 and f Healt item 2 othar		20a. Method of Disposition	) Tou	Luigh Per	Place of Disposition	Name of	Date	270	Oc. Location - C	ity or Town, State			
ē	8° = 5		1 ☐ Burial 2 ☐ Crem 1 ☐ Donation 5 ☐ Of		temoval from State	cemetery, crematory	or other place)	1/7/	077	3, 14.	am Mi)			
	_ <b>5.5.</b>		21. Signature of Funeral S			22 Nam	and Address of Facility	50-	2000	XX111	D.C.			
ñ	Depar Depar Impor any ir		1 Gun	W.	Aui	516	Mation	seri	ices a tio	arel fr	he MD 21229			
			23a. Part 1. Enter the disease shock or heart failure	ase, or compl	lications that caused the dear	th. Do not enter the	node of dying, such as ca	rdiac or res	spiratory arre	st,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	s. List only o	HYPOXIA		5 Hours							
	/Medical		resulting in death)		Due to (or as a consec		1-							
	Examiner		Sequentially list conditions		MULTILOBAR PNEUMONIA 5 DA									
	od sit	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	• 2	Due to (or as a consec		11 MONTH							
	be executed sician and burial-transit	хал	Cause Cities of notifying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								11 10010[1]			
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β	ficate g phys				0.									
X Q	n certifica anding ph use as th	2	IF FEMALE: 23b. Was decedent pregna	ant 2	23c. If yes, outcome of pregn		o progpanov			23d. Date of delivery				
	the death y the atten ached for u	Physiclan/Med	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  1 ☐ Yes 2 ☐ No  9 ☐ Unknown							Mont	h Day Year			
J.	at the by the	Phys	9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 23e. Did tobacc								to use contribute to the cause of death?			
<u>v</u>	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as the	ρ	Part II. Other significant c	onditions co	ntributing to death but not res	suiting in the underlyi	ng cause given in Part i.		1 ☐ Ye		□ Probably 4 □Unknown			
Hecord	requi	Completed									7 / -			
ခွ	e law has b	du						-	24a. Was ar autopsy perform	/ pri	ere autopsy findings available for to completion of cause of ath?			
_ 									1 ☐ Yes 2	1 1	Yes 2 No			
VIII V	Physician: The law this certificate has I ral director, page 2 s	o Be	examiner?							eath (Check only one)  Home 5 ☐ Residence 6 ☐ Other (Specily)				
5	₽ ± E	n: To	27. Manner of Death		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			w injury occurre				
	Attanding F ir death. ector: After by the funera	atlo	1 Natural 5 2 Accident	Pending investigation	(MONTH, Day Year)	1 ☐ Yes 2 ☐ No	·							
N N	If or Attandir after death. I Director: Af d in by the fu	tific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street at building, etc. (Specify)								r or Rural Route Number,			
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	Hospi 4 hou Funer ely fill	edical	29a. Certifier ↑ Co (Check only 2 ☐ M	ertifying Phy edical Exami	sician: To the best of my known iner: On the basis of examination	owledge, death occu ation and/or investiga	red at the time, date and tion, in my opinion, death	place, and occurred a	due to the ca It the time, da	use(s) and man ite and place, ar	ner as stated. nd due to the cause(s)			
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Med	one) 29b. Signature and title of	certifier	and manner stated.		29c. License number		25	d. Date signed	(Month, Day, Year)			
	To Wil		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  UEN NOWEN THE JULINS HORVINS HOSPITAL LOO NORTH INCLES STREET, BALL  31. Date filed (Month, Day, Year)  NOV 1 3 2007							INCHAN DA	TP = 2007			
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0	)		UEN YOUYEN	11 = TO	LANS HORKING IN	SPITAL LM	NORTH INCL	FE 5TE	GET BI	ALTIMORE.	MARY, AND 20287			
	Sta	ite	31. Date filed (Month, Day	Year)	32. Figistrar's Sign	atur	82 6							
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER Day +RANCIS 200 LAINE Facility Name (If not institution, give street and number) City, Town or Location of Death 4c. County of Death BACTIMORE WASHINGTON NEDICAL GLENBURNIE 8. Date of Birth (Month, Day, ) Jan. 30 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Year) Days Hours 1 □ M 2 🛛 F 214-42-4900 MD 62 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☑ No Marvland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 604 N. Avondale Road 21222 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Hairdressing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Wright Ruth Hybcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Gorman (son) 604 N. Avondale Road, Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 13 20a. Method of Disposition 20c. Location - City or Town, State Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licens Stallings Funeral Home, P.A. 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumou Jacks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

/Medical Examiner and burial-trar P.O. Box 68760, the attending physician the signed by the Division or Vital Records, certificate has Hospital or Attending

Physician/Medical Certification: To After this funeral 24 hours after death. filled in by the

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Completed

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**Physician** 

/Medical

Examiner

Directo

Funeral

Completed by

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**Funeral** 

Director

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other t any Injury or other traumatic event, th

Physician

Baltimore, Maryland 21215-0036

State Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

hartes

MD Hospital Drive Glen Burnie MD

Medical

31. Date filed (Month, Day, Year)

NOV 1



DHMH 17 Rev 1/2001

within 2

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea GILBERT **Physician** GERALD 19:00 1 NOV 03 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) April 8, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours New Jersey 1 M 2 □ F 72 053-28-4561 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Highland Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7653 Green Dell Lane 20777 U.S.A. 'natural", or items 23a permit. Pages 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" -- " any injury or other trainer." Funeral 14. Race - American Indian. 12, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 TYPes 2 □ No s, Give or Dates 1 ☐ Yes 2 🔀 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Package Goods Store Owner Own Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Fischer William Henry Gilbert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7653 Green Dell Lane Highland, MD 20777 Evelyn Gilbert 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 11-9-2007 Metro Crematory Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Witzke Funeral Homes, Inc. 5555 Twin KNolls Road Columbia, MD 21045 M01050 adema 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY Physician FALURE 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): days Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9☐Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 29a, Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062560 Nov 03, 2007

Division or Vital Records, P.O. Box 68760,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRUMMOND

10724 Little Patrient Parkway # 200 Columbia, MA 32. Registrar's Signature Contraction of the second

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:45P M 2007 Edwin Standish Gifford November 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerford Place Columbia Howard 8. Date of Birth (Month, Day, Year) March 7,1927 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 ☐ F Days Hours Min. 80 Yrs. 039-18-3164 Director Massachusetts Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show a or 28a-f sh 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21144 items 23a oner must b 1818 Manet Court U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 □ Divorced White Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) the M Elementary/Secondary (0-12) College (1-4or 5+) Television Technician Sears is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beetle Paul Gifford 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra 1818 Manet Court Severn, MD 21144 Darlene O'Sullivan (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-13-2007 Middlevillage, NY Lutheran Cemetery 4 □ Donation 5 Other (Specify) 21. Signature of Au Teral Service Litensee ^{22. Name and Address of Facility}
Witzke Funeral Homes,
5555 Twin KNolls Road WOIDSV Inc. Columbia, MD 21045 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's, dementia **Physician** 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cate has page 2 s autopsy performed certificate 2XNo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  Dother (Specify)  $_{1}$  Living 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death.

Director: / 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours are
To the Funeral Dir 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. D56531 Nov. 7,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Parkway, Suite 301 Columbia, MD 21045 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 1 3 2007 Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of Ma		artment of F		ınd Mental Hy	giene 0	7 36183
ŀ			1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
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	er any company to the conference of		Somerford Place				mbia	Milko de a composições		<i>v</i> ard
	Funeral		5. Social Security Number 6. Sex 1□	M 2 <b>⊠</b> F 7. Ag	e (In yrs. last birthda) TE Yrs.	Months Days	If Under 2 Hours	8. Date of Bir Min. (Month, Da May 29	th ly, Year)	9. Birthplace (State or Foreign Country)
964	Director		Usual Residence of Decedent		75 Yrs.		l	May 29	, 1932	Pennsylvania
	yland now		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f st	ctor	Maryland Anne Art	undel	Sever	l				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
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<u>a</u>	12 sh n and rs m raum		19a. Informant's Name/Relationship (Typ	•				er or Rural Route Numb		State, Zip Code)
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		ja e	Sequentially list conditions, if any, leading to immediate cause. Enter Underging		a consequence of):					
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Division or	Phy er this eral d	.T	27. Manner of Death	28a. Date of Inj	ury 28b. Time	of 28c. Inju	4 🗆 INU	rsing Home 5 ☐ Res 28d. Describe	how injury occurre	
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N S	Attender death	ifice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	jury - At home, farm, : tc. (Specify)	street, factory, office		28f. Location	(Street and Number	er or Rural Route Number,
	tal or s afte al Dir ed in	Certification:	, <u></u>	bullating, c				City of Te	wii, State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, is	edical (			of examination and/or			nd place, and due to the ath occurred at the time		nner as stated. and due to the cause(s)
	Fo the within Fo the Somple	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
				Kha	M.D.	D5	6531		Nov.	7, 2007
	1		30. Name and address of person who co	mplet duse of	death (Item 23a) (Typ				- C-10 - 150	
	(				ver Pkwy,	Suite 301	Colu	mbia, MD 2	1045	
		ate	31. Date filed (Month, Day, Year)	#	rar's Signature	(12)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 3. Time of Death 2. Date of Death **Physician** 9 AM 2007 an /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner IA Marg of lance a move If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🖫 F Days -0 Director May Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any; If item 27 is marked other than "hatural", or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ma Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 21215 Y Ola Northway Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) dont e as 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ENO exc ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mother back, md north Aption verne 2404 ovola Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ) cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State md. materi atonsville 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of F cility 21. Sunature of Funeral Service Licknsee Manco Wallace md. 21229 lla m. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin a disease or condition resulting in death) Physician neumo /Medical Du. to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardiomyopathy law requires that the death certificate be executed the burial-transi tum and Due to (or as a consequence of) attending physician Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. be detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, PONO 3 Probably 4 Unknown 1 ☐ Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 K No The certificate 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ko Certification: To 1 npatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day or Attending Year) 1 Natural Accident 5 Pending investigation 1 Yes 2 No death. after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AH 12 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene 36185 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Charles L. Gregory Nov 2007 2:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner John Hopkins Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 2,1943 **Funeral** Months 1 🕁 M 2 🗆 F Yrs 22**7-**54-6187 Director 64 Virginia Usual Residence of Decedent 10b. County death with the Maryland MD State 10d. Inside City Limits
1 ☐ Yes 2 ☐ No 10c. City, Town or Location Baltimore r then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5310 Goodnow Rd. 21206 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hyglene. 1 ☐ Yes 2 ☐ No If Xes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xo Specify: Specify: Black Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hyglenn Important: If item 27 Is marked other the any injury or other traumatic event, Italian 2002. Correction Officer Dept Of Correction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sam Gregory Estelle Rolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Queen Young Sister 1323 Oats St. Capitol Heights Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State Union Hill RUZA 11/17/07 * 4 ☐ Donation 5 ☐ Other (Specify) Baskerville, Va. 21. Signatur of Funeral Service License 22. Name and Address of Facility M01510 22. Name and Address of Facility Feegins, Funeral Home 409 South Hill Ave South Hill, Va. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mgestil /Medical Due to (or as a consequence of) **Examiner** ys temie Sacuration list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and I for use as the burial-transit Division of Vital Records, P.O. Box 68760,ぞ The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) , the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate 21 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 □ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident -3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 12 Certifying hysicia: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
25 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) RNEST M. 31. Date filed (Month, Day, Year) NOV 1 3 2007 32. Registrar's Signature State TOWN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov. 4, Year 2007 **Physician** 2:00 аМ Carrie Ε. Glover /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Sacred Heart Home Hyattsville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Nov 2 ) 5. Social Security Number 7. Age (In vrs. last birthday 6 Sex **Funeral** 1912 Maryland 138-03-9188 1 M 2 F 95 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐Yes 2 ☐ No Director MD Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20782 USA 5805 Queens Chapel Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Saltimore, Maryland 21215-0036 2 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within inent of Health and Mental Hygiene.
Int: If item 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary/Clerk Dept. of Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Gipson Gertrude Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 1012 Douglas St. NE, Washington, DC 20018 James Washington/Godson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ F 4 ☐ Denation 5 ☐ Other (Specify) 3 Removal from State Olivet Cemetery | 11/09/2007 | Washington, DC 22. Name and Address of Facility Robert G. Mason Funeral Home, Inc 21. Signature of Funeral Service Licens 1661 Good Hope Road, SE, Washington, DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Heart Disease years /Medical Due to (or as a consequence of) Examiner Hypertension
Due to (or as a consequence vears Sequentially list conditions to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Arthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s Multi organ failure autopsy performed? 1 Yes 2 XNo or Attending Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 Ño မှ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and till of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli M.D. 10810 Darnestown Rd. Ste. 202, Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

FRAZELL

GLOVER,

900 Caton Avenue Baltimore, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Michael S. Ballo,

3

31. Date filed (Month, Day, Year)

November 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 7 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** NOVEMBER 10,2007 11:25PM Robert W. Grill, SR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-23-1918 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months | Days Hours Min 1**K** M 2 □ F Mary Land 220-30-3496 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1★ Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a any Injury or other traumatic event, the Medical Examiner must a once. itеms 23a 3315 Parklawn Ave 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 □ Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Improvements 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert M. Grill Marie Stetter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen I. Grill (Wife) 3315 Parklawn Ave. Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 11-16-2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd. Nottingham, MD 21236 21. Signature of Funeral Service Licenses Du 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SQUAMOUS CELL CARCINOMA OF ANUS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin the Hospitai or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEVERE MUCOSITIS 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No NEUTROPENIA 24a Was an autopsy performed? (es 2**X** No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 🔀 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

BOON POH LIM.

7601 OSLER DRIVE, TOWSON, MARYLAND 32. Registrar's Signature

NOV 1 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 37254

07

		1 - For State Registrar		ar y turic		rtificate			Mental Hyg	g. No.		
Physicia	an	1. Decedent's Name (First, Middle, La Charlie Th		ganus	III			NT -	2. Date of Deat Month	Day	Year	3. Time of Death  10:05 A
/Medic Examin		4a. Facility Name (If not institution, given 4900 Lyon Hear						r Location of Death Mills	vember 0	4c. Coun	ty of Death timOi	
uneral		Social Security Number 6.3		ge (In yrs. la 54	ast birthday Yrs.	) If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			place (State or Foreig
ector		Usual Residence of Decedent		100 City	, Town or t				July 31,	1953		n Carolina
other traumatic event, the Medical Examiner must be notified at	ctor	Maryland Baltin	nore	1	ngs M							10d. Inside City Limit
at be no	al Dire	10e. Street and Number 4900 Lyon Heart	Drive Ap	t A		10f. Zip C	ode 211	17		og. Citizen of ited S		of Ameri
SALL IN LINE	by Funeral Director	11. Marital Status  X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	5. 13	Was Deceder If Yes, specific		lispanic Origin? (Si an, Mexican, Puent Specify:	pecify Yes or No- o Rican, etc.)	ВІ	ace - Ameriack, White	
	leted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dec	edent's Usual e kind of work	Occup done	ation during most of wor	king	16b. Kind of		•
	Completed	Superintendent					piniello Construc Companies		onstruct10			
	To Be C	17. Father's Name (First, Middle, Last)  Charlie Thomas Gurganus , Jr.  18. Mother's Name (First, Middle, Last)  Neva Louise Win										
		19a. Informant's Name/Relationship				•		and Number or Ru				
		12 Burial 2 Cremation 3 Removal from State Forest Lawn Cemetery 11/10/07							20c. Location	- City or T	33470 Town, State rginia 235	
once.	-	21. Signature of Funeral Service Lice	I IMUU									irectors,I land 21133
an		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	o the death								Approximate Interval Between Onset and Death
al er		resulting in death)	Due to (or as	s a consequ	ence of):	0 100		inlan	doses	vse)		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consequ	ence of):	7 00	$\sim$	nem				
	cai Examiner	$H_{\gamma}$										
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes}, \text{ outcome of pregnancy} \) 1 \( \text{Live birth} \) 2 \( \text{Fetal death} \) 4 \( \text{Pregnant at time of death} \) 9 \( \text{Unknown} \) 9 \( \text{Unknown} \) 9 \( \text{Unknown} \)								Pate of deliver	very Day Year	
	ρ	Part II. Other significant conditions	contributing to death I	but not resu	Iting in the	underlying cau	ıse gıv	en in Part I.	23e. Did tot			the cause of death?
	Completed								24a. Was a autops perform	n 24b y ned? 2 ZNO	. Were aut prior to d death? 1 \( \sum \text{Yes}	opsy findings available opposed findings available of cause of 2 No
200	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpati	ient 2 🗆 E	ER/Outpati	ent 3□ DOA	Oth		ome 5 Reside	e) ence 6 🗆 O	ther (Spec	ıfv)
		27. Manner of Death  1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time Injury	of 286	c. Injur Wor		28d. Describe ho			
d in by the funeral director, page z snould be delached	Certification:	3 Suicide 6 Could not 1	28e. Place of In	njury - At hor tc. (Specify	me, farm, s				28f. Location (St City or Town		nber or Ru	ral Route Number,
completely filled in	Medical C	29a. Certifier Check only one) Certifying P	hysician: To the best miner: On the basis and manner s	of examinati	vledge, dei ion and/or	ath occurred at investigation, in	the tir	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and r ate and place	nanner as , and due	stated. to the cause(s)
completely filled in by the fu	Me	29b. Signalure and title of certifier	(			29c.		e number		9d. Date sign	ned (Month	Day, Year)

Registrar DHMH 17 Rev 1/2001

State

21230

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien  $^{f 2}$  0 0 736190 For State Registra Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 10, 2007 **Physician** 2:00 PM (MMN) **GRASSO** LISA November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 3064 Sounding Drive Edgewood II Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
June 30, 1950

8. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗗 F Yrs 57 094-42-2434 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: if Item 27 is marked other than "natural", or items 23e or 28e-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23e or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Edgewood Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 USA 3064 Sounding Drive Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2X No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Miriam (nmn) Schechter Eugene Victor Aronow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3064 Sounding Drive, Edgewood, Maryland 21040 <u> Michelle Crisanti / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Buria 3 □Reproval from State permit. Page Department o Important: if any injury or 2XX remation 4 Doglation 5 ther (Specify) Hilltop Service Corp 11-13-07 Towson, Maryland 21. Signature of Funera McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complete the claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? Year 4☐ Pregnant at time of death 5 Other (specify) detached ₽ 13 19 19 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 ☑ Unknown Brain Matastasis from Lung Cancer peeu 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No 1 Yes or Attending Physician: Olrector: After this certification by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home State Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No deeth. 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) nd manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat 9 moleted cause of death (Item 23a) (Type, Prin 31. Date liled (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician VOUEN BER <u>11:3</u>5 a^M 2007 GOODIN ADELE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2907 BRIGHTON STREET BALTIMORE Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours 1 □ M 2 🕱 F 83 VIRGINIA Director Jan 25 1924 145-22-3898 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1√Yes 2 No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2907 BRIGHTON STREET Funeral 21216 U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Introduce it it is marked other than "natural", or iter important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner ana. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify: BLACK þ 3 ₩ Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade DOMESTICE ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OTIS ROBERTS MAGGIE WINN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila R. Smith/Grandaughter 1616 McCulloh St., Apt 2, Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND KING MEMORIAL PARK 11-17-07 21, Signature Funeral en la Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** erchrovascular weck /Medical Due to (or as a consequence of): Examiner pertensia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

2

State Registrar Box

TOWSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Alexander

NOV 1 3 2007

31. Date filed (Month, Day, Year)

State Registrar SABATUNDE

31. Date filed (Month, Day, Year,

NOV 13

2007

2434

AJAN 1

32 Registrar's Signature

W. BELVESERE AVE BATTIMORE MAZIZIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Trem 21 per file 8873 11/29/07dhb
State of Maryland 2 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:30 PM Joanne Hughes 9,2007 Lena Novem ber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Hospital 134 Homore Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 6. Sex If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 📉 F 61 229-62-2240 09/24/1946 VA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. ¥ Yes 2 No Director MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4726 Wakefield Road #103 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by Specify: **Black** 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physical Education Teacher Baltimore City Schools 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hart Estelle Watkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hughes Jr. - Son 4726 Wakefield Road, #103 Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Forest Lawn 11/16/2007 Richmond, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility

March Funeral Home West, 4300 Wabash Avenue, 21. Signature of Funeral Service Licensee Lola March per DVR Baltimore, MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PSIS 10 days /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician as the t IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown tate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? es 2 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 npatient 2 ER/Outpatient 3 DCA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 21, 2007 m. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sina: Hospital 31. Date filed (Month, Day, Year) 32. Pojistrar's Signature State NOV 29 Registrar

State of Maryland / Department of Health and Mental Hygien n 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year Physician HARRIS 1835 M 2007 JAMES NOVEMBER 07 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CITY BALTIMORE HOSP ITAL MOPICINS NA THE JOHNS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5–21–1953 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 □ F S.C. 251-86-0681 54 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County M∏Yes 2∏No Director Baltimore NA Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 3110 Cliftmont Ave. USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Spe**Black** 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Driver NA 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pitts Johnnie Mae ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Tresia Harris Wife 3110 Cliftmont Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or 11-14-07 Greenmount Cem. Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East lady Warren 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to or as a consequence of): hour disease or condition resulting in death) /Medical Examiner stage renal disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine HIV The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 19 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P 28a. Date of Injury (Month, Day eral Director: After th filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 LEYNG MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE JOHALS HOPKINS HOSPITAL, 600 N WOLFE ST, BALTIMORE, MD 21287 JANICE LE UNG 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 17 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 8:45 P M NOVEMBER 11. 2007 WILLARD DALE HORTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Aberdeen 1125 Carsins Run Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months 1 XM 2 ☐ F May 8, Virginia 190-28-7600 70 1937 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r than "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 21001 1125 Carsins Run Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ◯XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry
Commercial & Residential 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Utility & Asphalt Comp. 12 Truck Driver other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental I is marked Nellie Fay Noblitt Arlie Dale Horton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
eny injury or other trau 1125 Carsins Run Road, Aberdeen, Maryland 21001 Cheryl D. Horton / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Angel Hill Cemetery 11-15-07 4 □Donation 5 □ Other (Specify) Havre de Grace, MD Fineral Se 21. Signatus 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LATERAL SCLEROSIS **Physician** AMYOTROPHIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physicien and s the burial-transit Box 68760% resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending ( 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached to 1 ☐ Yes 2 ☐ No o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by CORONARY ARTERY DISEASE 2 No 3 Probably 4 Unknown 1 ☐ Yes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DYSLIPINEMIA ete has t page 2 s autopsy 1 ☐ Yes 2 ☐ No certificete 1 ☐ Yes 2 XNo Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Funarel Director: After the completely filled in by the funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Natural 5 Pending 1 □Yes 2 □No deeth. investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours efter To the Funaret Dire 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 045344 11/12/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W, SURESH DHANJANI, MD, 622 S. UNION AVE, HANRE DE GRACE, MD 21078

1. Date filed (Month, Day, Year)

32. Appetrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 3

2007

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State of Maryland / Department of Health and Mental Hydiene

2007

330pm Flediliser		1- For State Registrar	Certificate		iu ivieritai i		2 U U	1 30130
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Deat	h	3. Time of Death
^চ ্নবical Examin	ner	Joseph G. Heuisler  4a. Facility Name (if not institution, give street and number)		Lab City Town o	r Location of Dea	Month November	7, 2007 4c. County of Death	1346 hrs
		43 North Kresson Street		Baltimore	r Location of Dea	iui	N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	<u> </u>		rs. 8. Date of Bir	th (MM/DD/YYYY) 9. Bir	hplace (State or Foreign
Director		218-28-6633 1XM 2 F	73	Yrs. Months Da	ys Hours M	in. FEB 12	100%	untry) Cyland
any		Usual Residence of Decedent  10a. State 10b. County 10c	. City, Town or Loc	cation				10d. Inside City Limits
<b>*</b>	_	MD N/A	Baltimo					1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	Darcino	10f. Zip Code		11	Og. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once		43 North Kresson Street		21224	4		USA	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	neral	11. Marital Status 1 Never Married 2 Married Armed Forces?		Was Decedent of H If Yes, specify Cuba			14. Race - Ameri White, etc.	can Indian, Black,
fter de I'', or i	y Fun	3 Widowed 4 Divorced If Yes, Give Year		Yes 2 X N	o specify:		Specify: Wh	ite
hours a 'natural Examin	ed by	15. Decedent's Education (Specify only highest grade complet	(ed) 16a. Deced	dent's Usual Occupa			16b. Kind of Business/	ndustry
36 thin 72 he. than "1 edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		1 Worker			Bethlehem	Ctool
215-0036 be filed within 72 ntal Hygieneked other than 'ent, the Medical	Som	9 17. Father's Name (First, Middle, Last)	stee	I WOLKEL	18.Mother's Nar	me (First, Middle, M		preer
1215 l be filt ental H nrked	Be	Joseph S. Heuisler				leanor S		
MD 21 d 2 should b Ith and Mer n 27 is mar numatic eve	10	19a. Informant's Name/Relationship (Type, Print) Lillian W. Heuisler - wife					nber, City or Town, State ${ m e, \ MD \ 21211}$	
e, M I and 2 Health item 2		20a. Method of Disposition	20b. Place of Disp	osition (Name of co		Date	20c. Location - City or	
Pages ent of nnt: If		Burial 2 X Cremation 3 Removal from State  Donation 5 Other Specify:	Metro Cr	. ,	Inc. 11	/10/2007	Baltimore	, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med		21. Signature of Funeral Service Licensee H. William					yland, Inc.	
		23a. Part I. Enter the disease, or complications that caused the		299 Frede	erick ko	ad, Balt.	imore. MD Z	1228 Approximate Interval
Physician /Medical	178	failure. List only one cause on each line.			,,	· · <b>- ·</b> · - · · · / - · ·	,,	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Care Due to (or as a conseque						
	-	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a conseque	ence of):					-
	amine	cause. Enter Underlying Cause (Disease or injury that initiated						
executed in and il - transit	ŭΙ	events resulting in death) Last Due to (or as a conseque d.	ince or).					
4 10 10	Medical	UNPENDED						
		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		Fetal death 3	Ectopic preg	inancy	23d. Date of deliver	y Day Year
Box 687  death certific  the attending p	sician/	past 12 months?		Other (Specify)			Monar	ou, rou.
the dea	Phys	Part II. Other significant conditions contributing to death but	t not resulting in th	ie underlying čause	diven in Part I	23e. Did to	obacco use contribute to	the cause of death?
P.O.	þ	chronic alcoholism		o ansonying cases	9.70.		s 2 No 3 Pro	
of Vital Records, ig Physician: The law require the three that the thin the thin the thin the thin the thin the thin the thin thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thi	Completed					24a. Was		topsy findings available completion of cause of
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tal Recition: The certificate rector, page	Bec	25. Was case referred to medical examiner?		26.Plac	ce of Death (Che	ck only one)		laponers'
f Vit	은	1 Yes 2 No Inpatient	2 ER/Outpatie		Other: A Nur.		Residence 6 Othe	r: Scene
ion of tending Pleath.  or: After the funeral	igu	27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	200. Time (	· ' · · · ·	Yes 2 No	200. Describe	now argury occurred	
Division Ist or Attendin rs after death. al Director: A	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, s	treet, factory, office	building, etc.		Street and Number or Ru	ural Route Number, City
Dispital of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	Certification:	4 Homicide determined (Specify)				or Town, S	tate)	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examina						
To T Com	Medical	and manner stated.  29b. Signature and title of certifier			se number		29d. Date signed (Mo	
		Theodo M Mr. c/ To		0.0	.M.E. 00	CME	November 8, 20	07
1		30. Name and address of person who completed there of death		444 = -		115 015		
		Theodore M. King, Jr., MD. Assistant Media.  31. Date filed (Month, Day, Year)  32. Revistrar's S		111 Penn S	treet, Baltimo	ore, MD 21201	1	
Sta	ate	31. Date filed (Month, Day, Year)  32. Fey Strar's S	igilatuis					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

8824 Trimble Way - Baltimore, Maryland 20c. Location - City or Town, State Crematory, Inc. 11/13/2007 Baltimore, Maryland

22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23d. Date of delivery Year Month Dav 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) -09-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE STREET BALTIMORE, MD 21201

10:52

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 XNo

Maryland

White

2007

Black, White, etc.

AIN

State Registrar

31. Date filed (Month, Day, Year)

3 2007 MD

10

MD

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Audrienne Mary Haffner November 09 2007 0500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗷 F 217-22-1142 Director 81 11-04-1926 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Maryland Harford Bel Air 1 ☐ Yes 2 ▼No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive by Funeral 21014 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No White Specify: 3 ☐ Widowed 4 ☑ Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Meany once. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Insurance Underwriter</u> <u>Insurance</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anton F. Kralicek Josepha M. Hlavac 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Audrey Ashbrook - Daughter 500 Mauser Drive Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/10/2007 Towson. Maryland 21. Signaum of Funeral Scruic, Licensee 5305 Harford Road Baltimore, MD 21214 22. Name and Address of Facility Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KespiraTor /Medical Due to (or a consequence of): Examiner Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Phatractive by monary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No B1000 death? 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 114 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Records, Division or Vital To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of

500 Bemile 31. Date filed (Month, Day, 32 Registrar's Signature Year

NOV 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

V0066366

Upper Chesapeaka Drive Bel Air, MD 21014

29d. Date signed (Month, Day, Year)

11-04-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08714 36199 State of Maryland / Department of Health and Mental Hygiene 2007 Cara Ann Siegel Hare Certificate of Death Reg. No 1- For State 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 9, 2007 Physician/ 1118 hrs HARE SIEGEL ANN Merlical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Owings Mills 4415 Kentford Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Country) MD Director M 2 X F 219-70-5449 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 X No OWINGS MILLS MD BALTIMORE or items 23a or 28a-f show must be notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number U.S.A. 21117 4415 KENTFORD ROAD 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Funeral White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married Never Married Yes WHITE Specify: Yes 2 X No specify: If Yes, Give Year 4 Y Divorced Widowed event, the Medical Examiner 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MORTGAGE 72 LOAN PROCESSOR marked other than 2 more, MD 21215-0036
Pages 1 and 2 should be filed within 7:
nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) STEINBERG IRIS Be LAWRENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 FARMHOUSE COURT - BALTIMORE, MD 21208 FATHER LARRY SIEGEL / item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition SHAARET TETLOH CONG. WOODLAWN, MD 11/12/2007 rtant: If it X Burial Removal from State Cremation 3 Other Specify. SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signat e of Funeral S rvice 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva en Onset and **Physician** Death failure. List only one cause on each line. "Medical Chronic obstructive pulmonary disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): **x** AMENDED **8 per fh g873 11-13-0/ yt x** AMENDED **#23a,PII,27,perME,g873, 11/27/07 TT** Physician/Medical X UNPENDED physician certificate be 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760. IF FEMALE Year Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 2 ed by the attending detached for use as t past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown The law requires that the death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. No 3 Probably 4 V Unknown Yes 2 è Fibromyalgia 24b. Were autopsy findings available 24a. Was an Completed of Vital Records, prior to completion of cause of autopsy death? performed? No 2 director, page 2 Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Residence 6 Other: Scene Be Other' Nursing Home 5 Hospital: 1 ER/Outpatient 3 Inpatient this 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death After Certification: 1 Yes 2 1 X Natural Division Director: the 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 10, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCMF 2006

State

Registrar

2007

Patricia Aronica-Pollak MD.

31. Date filed (Month

Assistant Medical Examiner

egistrar's Signatur

MARIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08581 State of Maryland / Department of Health and Mental Hygiene 2007 36200 John C. Houston Certificate of Death 1- For State Rea. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 4, 2007 Physician/ 1210 hrs √ Examiner Houston Medic John 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Rosedale Franklin Square Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. ForeigMaryland Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours June17,1958 49 Director 215-66-3530 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ij 1 Yes 2 X No Baltimore Essex or items 23a or 28a-f show must be notified at once. Md. Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number U.S.A. 935 Arncliffe Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: 1 Yes 2x No specify: White 4 X Divorced If Yes, Give Year Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Trucking Truck Driver 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Donahue John Crave Houston, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) 935 Arncliffe Rd. Baltimore, Md. Juanita Houston (mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11-9-07 Baltimore, Maryland Bayview Crematory Other Specify: Donation 5 22. Name and Address of Facili Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death **tailing** Complication of myocardial infarction Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Hypertensive atherosclerotic cardiovascular diseas Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical attending physician or use as the burial -X UNPENDED #23a-b,PII,27,perME,g873, 11/16/07 TT 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the past 12 months? Live birth Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown detached for 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 No 3 Probably 4 V Unknown Completed by Cocaine use 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes No ✓ Yes 2 page 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other Nursing Home 5 Other examiner? Hospital: 1 / Inpatient 2 Residence 6 DOA ER/Outpatient 3 1 V Yes No 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending Director: d in by the f 24 hours after death. 28f, Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier November 5, 2007

State Registrar

Donna M. Vincenti, MD 31. Date filed worth Dry, 3ar 200

Noma Mincorti, M.D. 30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registrar's Signature

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itemstate permanular 8876 partinell of Health and Mental Hygiene Amend Items 10c,e.f.per 52,8873,611/28/07dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Margaret Α. Ireland November 8. 2007 10:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 22,1921 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X 1 86 214-14-4132 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2\\No Baltimore Lansdowne Parkville with the 10e. Street and Number 10g. Citizen of What Country? 2423 Zion Rd. 10f. Zip Code ° 21227 <del>21234</del> 8202 Evergr USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Important: If item 27 is marked other than any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) Cafateria Aide Balto Co. Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Adam Kuchta Madeline Kuchta ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline Fitch (Daughter) Baltimore, Maryland 21234 8202 Evergreen Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 11/13/07 Glen Burnie, Maryland 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 17250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes **Physician** 40 card /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trar and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy 1∐ Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 

Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number and title of certifier 29d. Date signed (Month, Day, Year) November 12, 2007 death (Item 23a) (Type, Pr

State Registrar

3

Rd. # 202, Baltima, MD 21228

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JEFFERSON Dav Month Year THELMA 6:22 A,M NOVEMBER 00 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS HOSPITAL CITY BALTIMORE NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 M 2 F 218-18-3388 84 11-25-1922 Md. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TyYes 2 □ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809 E. Preston Street 21202 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Gov't Employee Commucation Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph SARAH Trusty Bouldin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Smith 809 E. Preston St., Baltimore, Md. Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 11-15-07 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cause (Final disea o resulting condition death) ANOXIC BRAIN INJURY 5 DAY Due to (or as a consequence of): 5 DAYS ASH PULMONARY EDEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PROGRESSIVELY WORSENED CHRONIC RENAL FAILURE 6 MONTHS Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐Unknown Month Dav Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an CHRONIC OBSTRUCTIVE PULMONARY DISEASE autonsy 2 **2** No DIABETES MELLITUS 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 27. Manner of Death 28a. Date of Injury 28h. Time of Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

NOVEMBER 09, 2007

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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death Items

filed within 72 hours after

Maryland 21215-0036

altimore,

Box 68760

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Records,

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Physician:

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To the Hospital

after

within 24 hours

Examiner must

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Director

Funeral

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Examine Physician/Medical ģ Completed

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P

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3□ Suicide

29a. Certifier

Certification:

Medical

burial-tran attending physician use as the for ned by the a signt 1 be ( page 5 this certificate funeral ( After reral Director: A death.

To the Funeral

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGEL CHAN, State

31. Date filed (Month, Day, Year)

600

5 Pending investigation

6 ☐ Could not be

determined



(Month, Day

and manner stated.

Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

STREET, BALTIMORE, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI line a per MD, g873 11/13/07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Brenda Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 176 HIMORE NA Year If Under 24 Hrs. Numb Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 1□ M 2□ F 218-46-5465 Yrs Director 60 8-11-1947 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Md. NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 726 Wharton Ct. 21205 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2X No Specify: à Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) event, the X-Ray Tech. Mercy Hospital 12th_grade Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ment of Health and Mental မ Ethel Conigland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health Felix Little Friend 208 Douglas Ct., Baltimore, Md. 21231 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or c once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Cem. 11-9-07 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Be 1101 E. North Ave., Baltimore, Md. Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Probable my cardial infarction. **Physician** MILLI disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trail that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4⊒Pregnant at time of death 5 ☐ Other (specify) hed by the a 9∏Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No certificate 1□ Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No the funeral director. Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Iniury after death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Sulcide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

November 1, 2007 29b. Signature and title of certifier 1)0058570

Md

Black

21202

Day

Year

Approximate Interval Between Onset and Death

10d. Inside City Limits

Y Yes 2 □ No

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

Amelia

Good

Same: ton Hospital MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Balter

32.

Registrar's Signature

Terrance

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:10 P.M NELL ORUM **JONES** November 2007 /Medical 6, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Ruxton Towson **Baltimore** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 💢 F 89 Director 220-07-9239 July 11, 1918 Alabama Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Funeral Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 628 Colorado Ave. 21210 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Completed by Specify: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Clerical State Accident Fund 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leila George Fagan Orum Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Stoll 1303 Rayville Road Parkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 11-10-07 New Cathedral Cemetery Baltimore, Maryland 22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** Subdural Hematoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 💢 No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1□ Yes 2∑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 5 Pending investigation 2 X Accident 3 ☐ Suicide October 13, 2007 Noon P. M 1 ☐ Yes 2 X No within 24 hours after death

To the Funeral Director: Fall 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 628 Colorado Ave. Balto. MD 21210 Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 11, 2007 THE WY 30. Name and address of person who completed cause of death (It an 23a) (Type, Print) ND Trimble 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 1 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** KSON NOVEMBER tn4hon4 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3 ALYIMORE CITY † Under 1 Year | ff Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 8-16-1961 5 Y. A GNES

5. Social Security Number 6. S PITAL 405 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 1 4 2 F 46 213-78-453 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e Street and Number 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ranspa 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be onald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a. Informant's Name/Relationship (Type. Print) HO.MD ham Ave, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 07 3 ☐Removal from State 21. Signature of Funeral Service License serve Funeral 1c Rd . Ra Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Lulti-organ /Medical Due to (or as a consequence Examiner 212452 week Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed iranori Due to (or as a consequence of): Box 68760, Hepatiti Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown signed by ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ ves 2 □ No mentro senia 24a. Was an autopsy performed? positive H(V -2 ☐ No certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO HOMAS. J. ENELOW 900CATON AVE BALTIMORE, MOJ 31. Date filed (Month, Day, Year) 32. Restrar's Signature State NOV 1 3 2007 Registrar

DHMH 17 Rev 1/2001

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who

31. Date filed (Month, Day, Yes NOV

ngu

DR BITT

DRIVE

21237

Baltimore

ause of death (Item 23a) (Type, Print)

4000 FRANKLIN Square

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ī.			Hegistrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	001	3. Time of Death
	Physicia /Medic		Ki Chung		Kim			Nov 8	Day	200 ^{Year}	12:41p M
	Examin		4a. Facility Name (If not institution, give street Univ. of Maryland		Syst	4b. City, Town, or Baltim			4c. C	county of Deat	h
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		) If Under 1 Year	If Under 24 Hrs.	8. Date of Birl	h	9. Birt	hplace (State or Foreign
	Director		031-64-6368 ¹ 反M 2	^{1□ F} 4	7 Yrs.	Months Days	Hours Min.	(Month, Da 12/10/			untry) 1, Korea
٦	pun ,		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or L	ocation					10d. Inside City Limits
	Maryla f shore	ō	Maryland Baltimore		rry Ha						1 ∐Yes 2 ⊠No
	r 28a-	Directo	10e. Street and Number	10	LLY IR	10f. Zip Code			10g. Citize	en of What Co ted. St	untry?
	th with 23a o		5013 Red Top Terra	ace		21128			of A	merica	
	er dea items ner mi	Funeral	Ar	as Decedent Ever in U. med Forces?	S. 13.	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	<ol> <li>Race - Ame Black, White</li> </ol>	
326	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by F	^_	⊒Yes 2⊠No Yes, Give ear or Dates:		1 ☐ Yes 2212 No	Specify:		8	Specify: as	ian
5-0036	72 hou natura lical E	ted	15. Decedent's Education (Specify only highest grade com	nleted)	(Give	edent's Usual Occupa e kind of work done o	lurina most of work		16b Kind	<b>Resear</b>	ch Lab. Air
12	be filed within 72 hours after death with the Marylan tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)	Resea	irch ^T Aeros Posearch	pace Eng.	ineeŗ		ems Bra	anch <del>overnme</del> nt
7	be filed w ntal Hygie ed other t event, th	S	17. Father's Name ( <i>First, Middle, Last</i> )	5+	-	- Colonia	Phd. 18. Mother's Nam				OVELIMENTE
<u>a</u>	ld be lental ked o	To Be	Hee Shin Kim				18. Mother's Nam June June	Ja Cho	1		
Maryland	es 1 and 2 should be of Health and Menta f item 27 Is marked ir other traumatic ev	-	19a. Informant's Name/Relationship (Type. Pi	rint)	19b. Mail	ling Address (Street a	and Number or Rui	ral Route Numb	er, City or	Town, State, 2	Zip Code)
	and 2 lealth m 27 I		Grace Kim / spouse			Red Top		Perry Ho		Maryla ation - City or	
altimore,	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition  12 □ Cremation 3 □ Remov	, c	emetery cit	osition (Name of ematory or other plac Vallev		mber			
	permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature of Juneral Service Licensee	Mem	2	Valley Gardens 22. Name and Addres	12,	2007			aryland
n	Depril Impo		Melto Bill		Pe	eaceful Al 2325 York	ternative	es Fune: imonium	ral & . Mar	Cremat	ion Ctr.,P.A
			23a, Pa V. Enter the disease, or complication shock, or heart failure. List only one call	is that caused the death	h. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory a	rrest,	4	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	etastatio	Gas	tric Can	cer				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
	cuted Id ransit	Examin	Cause (Disease or injury that initiated events c								
Ď,	oe exercian ar		resulting in death) Last	Due to (or as a consequent	uence of):						
58760,	death certificate be executed e attending physician and of for use as the burial-transit	dical	d								
BOX	n certif nding use as	Physician/Me		yes, outcome pf pregna					2:	3d. Date of de	livery
	at the death certif by the attending tached for use as	sicia	in the past 12 months?	□Live birth 2 □ Feta □Pregnant at time of d □Unknown		☐ Ectopic pregnancy☐ Other (specify)				Month	Day Year
J.	law requires that the as been signed by th 2 should be detache	Phy	9 ☐ Unknown  Part II. Other significant conditions contribut		ulting in the	underlying cause give	an in Part I	23e Did	hacco us	o use contribute to the cause of death?	
ds,	signe d be d	d by	Part II. Other significant conditions continue	ing to death but not res	unung in inc	and onlying oddoo give	on my sare n				robably 4 Unknown
Records,	w requires to been signer should be	Completed	-					24a. Was	an	24b. Were a	utopsy findings available
2	<b>sician:</b> The law certificate has b irector, page 2 s	omp						auto perfe 1⊟ Yes	psy ormęd? 2 <b>X</b> No	prior to death? 1 ∐ Yes	
Vital	sician: certifica rector, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea				
Ö	Sir d	ဍ	1 ☐ Yes 2 [XNo Hospit	al: 1 <b>M</b> npatient 2 □ a. Date of Injury	ER/Outpatie	ent 3 DOA Oth	4 □ Nursing H	ome 5 Res			ecify)
on O	ding I h. After funer	tion:	27. Manner of Death  1   Natural 5   Pending  2   Accident investigation	(Month, Day Year)	Injury	Wor	yat k? Yes 2 □ No	zou. Describe	now injury	occurred	
DIVISION	Atten r deat ector: by the	ifica	- D - Live C Could get be	e. Place of injury - At he building, etc. (Specif		street, factory, office			Street and wn, State)		Rural Route Number,
בֿ	ital or rs afte ral Dir	Certification:	A				4				
	To the Hospital or Attending PI within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner:	On the basis of examina	owledge, dea ation and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) , date and	and manner a place, and du	s stated. le to the cause(s)
	o the vithin 2 o the o the omple	Med	29b. Signature and little of certifier	and manner stated.		29c. Licens	e number			e signed (Mon	
)	->-0		> Whole May	MO		P221	13		Nov.	. 12,	2007
	4		30. Name and address of person who comple	ted cause of death (Iten	n 23a) (Type	e, Print)					
	9		Dr. Mohit Gilotra 31. Date filed (Month, Day, Year)	22 S. C	reen	e St. Ba	ltimore	, Md 2	1201		
	Sta Registr		NOV 1 3 2007	32. Registrar's Signa	e A	24863					
			LEGAT O COOL	Part State of Ass	- ANTES	To the Over					

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07-08653

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State of Maryland / Department of Health and Mental Hygiene 2007 36208 Wayne Keim, Sr. Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 7, 2007 Year 0510 hrs Wayne Keim, ⁱdical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** NB Route 702 ramp to Interstate 695 Essex If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) g. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Min Months Days Country) Director Jan. 23, 1963 Maryland 1 X M 2 F 212-86-1729 44 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County M 10a, State 1 Yes 2 X No or 28a-f show Dundalk Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number notified at United States 21222 7723 Fairgreen Road **23**a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Armed Forces? 1 X Never Married 2 Married after death White 2 X No Yes Specify: Yes 2 X No specify: Give Year Divorced 4 3 Widowed event, the Medical Examiner "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours and to Health and Mental Hygiene. Completed Heating, Ventilation, Elementary/Secondary (0-12) College (1-4 or 5+) Air Conditioning marked other than Technician 12 Years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Mae Sims William Howard Keim 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဂ္ litem 27 is m r traumatic 8163 Kavanagh Road Dundalk, Maryland 21222 Mr. Wayne E. Keim, II (Son) 20c. Location - City or Town, State 20h Place of Disposition (Name of cemetery Baltimore, I permit. Pages 1 and Department of Healt Important. If item injury or other tran 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 11/9/2007 Towson, Maryland Hilltop Service Corp. Donation 5 Other Specify: Signature of Funeral Service Lisensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED physician the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown à Completed 24b. Were autopsy findings available as been si 24a. Was an prior to completion of cause of autopsy death? performed? has 1 🗸 Yes page 2 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Be Nursing Home 5 Residence 6 ✔ Other: Scene Other; examiner' Hospital: 1 ER/Outpatient 3 Inpatient 2 1 V Yes 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Driver auto fixed object collision Certification: FOUND: Yes 2 V No 1 Natural Pending 0502 hrs Nov 7, 2007 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) NB Route 702 ramp to Interstate 695, Essex, MD Suicide (Specify) Interstate/Express Δ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 7, 2007 O.C.M.E. Donna MW incerti, MID. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

3 200

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amends: 145 of Maryland 1887 att 11 or 27 The and Mental Hygiene

			For State Of Registrar	Cer	tificate of D	eath	Reg	g. No.2 1 1 7	36209			
Г	Physicia	- 6	1. Decedent's Name <i>(First, Middle, Last)</i> Emily Keebler				2. Date of Death O Veriber	₽, 2007	0801 P _M			
	/Medio Examin		4a. Facility Name (If not institution, give street and num		4b. City, Town, or L			4c. County of Deat				
			The Johns Hopkins Hospita 5. Social Security Number 6. Sex 7	l l . Age (In yrs. last birthday)		imore City		N/ 9. Birt	hplace (State or Foreign			
è	Funeral Director		189-34-8833 1□M 2只F	66 Yrs.	Months Days	Hours Min.	Date of Birth	941 Ne	WithYork			
	and and t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits			
	Mary a-f she iffed a	tor	PA Lancaster	L	ancaster				1 ☐ Yes 2 ☑ No			
	ith the or 283	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co				
	s 23a nust t		1746 Billview Drive	lent Ever in U.S. 13.1	176		ifv Yes or No-	U.S.				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decet Armed For 1 □ Yes, If Yes, Give Year or Da	2 XNo	Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 🗖 No		ićan, etc.)	Black, Whit	e, etc. Vhite			
2	72 ho 'natur dical I	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of working	g   1	6b. Kind of Business/	Industry			
121	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4	4or 5+)	retary		0	ffice Info	ormation			
<b>d</b> 2	filed Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name						
<u>la</u>	uld be Mental Irked (	To B	Edwin A. McAlpin				e B. Du					
Maryland 21215-0036	nd 2 sho lith and i 27 is ma r traume		19a. Informant's Name/Relationship (Type. Print)  James E. Keebler - Husban		umber, City or Town, State, Zip Code) Ster, PA 17601							
Je,	of Hear		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5	20b. Place of Dispo cemetery, cres	osition (Name of matory or other place	) Da		20c. Location - City or				
<u>E</u>	Page ment g ant: If ury ol		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 8 4 ☐ Donation 5 ☐ Other (Specify)	Greenwoo	d Cemetery			Lancaster				
Baltimore,	permit, Depart Import any inj		21. Signature of Fineral Service Ucens	f: L	eonard J.	Ruck, Ind			Road aryland 21214			
250	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):									
	Examiner	ner	Sequentially list conditions	or as a consequence of):								
68760, 23	tificate be executed ig physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	or as a consequence of):								
		/Medical	IF FEMALE: 23c If yes out	come pf pregnancy				23d Date of de	livery			
P.O. Box	that the death cer ed by the attendin detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown			Month	23d. Date of delivery Month Day Year					
	S E e	þ	Part II. Other significant conditions contributing to de	ath but not resulting in the u	underlying cause give	n in Part I.	23e. Did tob		o the cause of death? Probably 4 □Unknown			
Division or Vital Records,	e law has b	Completed		<u> </u>			24a. Was ar autops perforn 1 Yes 2	y prior to	utopsy findings available completion of cause of			
/ita	y <b>sician:</b> Th is certificate director, pag	Be	25. Was case referred to medical examiner?		Otho	26. Place of Death						
or \	.s i∌	۲: ح	1 ☐ Yes 2 ☐ No 1 ☐ 1 ☐ 1 ☐ 1 ☐ 27. Manner of Death 28a. Date	npatient 2 ER/Outpatie	SIL SUDOA	4 □ Nursing Hon		ence 6 Other (Sp.	ecity)			
on	Attending I r death. ector: After by the funer	tion		h, Day Year) Injury		? ′es 2 □ No						
Divisi	in Life	Certification:	3   Suicide 6   Could not be determined 28e. Place buildi	2	28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,					
	e Hospital 24 hours a e Funeral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the b and mani	best of my knowledge, dea asis of examination and/or i ner stated.	th occurred at the tim nvestigation, in my op	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, d	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)			
	To the I within 2. То the I complet	Me	29b. Signature and title of certifier		29c. License			9d. Date signed (Mor				
			I Jennifer L. Berkele	<i>-</i>		~~			10,2007			
-	12		30. Name and address of person who completed caus Senn L. Reckeley, Go	e of death (Item 23a) (Type	St. Bulti	more, h	D 212	187				
		ate		egistrar's Signature								

			Pie	ease Type or Pri	nt in B	lack	Indelible Ink.	Ensure A	II Copies	Are	Legible.	
			For	State of M	arylan		partment of H		Mental Hy	giene	9	
			1 = State Registrar			C	ertificate of L	Death	-		2007	36210
	Physicia	ın	1. Decedent's Name (First, Mi						2. Date of Dea Month Novembe		, 20°07	3. Time of Death 12:00 DM
	/Medic		Helen L.	. Keuski ution, give street and number)			4b. City. Town, or	Location of Death	1		. County of Death	•
J	Examin	er	3747 Federal				Jarrett				Harf	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. I		Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h V. Year	9. Birth	place (State or Foreign
	Director		219-16-8739 Usual Residence of Decedent		83	Yrs			Nov. 2	9, 1	.923 Mai	ryland
3	ow at		10a. State 10b. Cou		10c. City	, Town o	Location					10d. Inside City Limits
	a-f sh ified	ctor	Md. Ha	rford	Jar	rett	sville					1 □Yes 2 No
-	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cou	untry?
=	s 23a	ral		eral Hill Rd.	From in 11 a	0 1	210		if- Van au Na	-	USA 14. Race - Amer	rican Indian
	ritem Iner n	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ N	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	,	5.	Was Decedent of H     If Yes, specify Cuba		o Rican, etc.)		Black, White	e, etc.
250	ral", or	by	3 X Widowed 4 □ Divor	rced If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify:			Specify: W	hite
ָר ה	be fleed within 72 nours after death with the Maryland tall Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Dece (Specify only hig	edent's Education ighest grade completed)		16a. De	cedent's Usual Occup ive kind of work done o e. DO NOT use retired	ation during most of wor	king	16b. K	ind of Business/I	ndustry
V :	than the Me	m Id	Elementary/Secondary (0-1	12) College (1-4or	5+)		e. DO NOT use retired ses Aide	1)		Ноя	pital	:
י ע כ	Hygi other ent, tl		17. Father's Name (First, Mide	Idle, Last)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		18. Mother's Nam	ne (First, Middle,		·	
0	Aental Aental rked tic ev	To Be	John A. Tho	mas				Kaysell	a Mars	hall		
<u>a</u>	and had is ma		19a. Informant's Name/Relati				ailing Address (Street					
≥ : ປົ .	Tand Health Sm 27 Sm 27 ther to		20a. Method of Disposition	ran/ Daughter	20b P		17 Federal		Date		ocation - City or	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 1 to Health and Mental Hygiene. Important: if the Mart and Mental Hygiene. Important: if the Mart 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ion 3 Removal from State			sposition (Name of crematory or other place)  Church	1	.0-07		lesvill	
Daltillor	ortan		21. Signature of Funeral Serv		J. C.	Mar	22. Name and Addre					e, nu.
ă	Depar Impo any Ir			1485			1050	York Rd	. Towson	n, M	id. 21204	4
			23a. Part1. Enter the disease shock, or heart failure.	e, or complications that cause List only one cause on each li	d the death ine.	n. Do not	enter the mode of dyin	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		di	menta					6 5 year
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/00	g phys	Physician/Medica		d								
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5	the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant e 9□Unknown	t time of d		5 ☐ Other (specify) _				Month	Day Year
Ĺ	ed by detac			nditions contributing to death b	out not resu	ulting in th	e underlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
cords,	The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	d by							1 🗆 '	Yes 2	Pro 3□ Pro	obably 4 □Unknown
) ပ	law re as bee 2 sho	Completed							24a. Was		24b. Were au	stopsy findings evailable completion of cause of
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VICAL	rnysician: r this certific ral director,	Be	25. Was case referred to med examiner?	Hospital:			Oth	26. Place of Dea				
5 8	r this eral dii	: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Inju	ury	28b. Tim	e of 28c. Injur	er: 4 Nursing H	ome 5 Resi			cify)
5	Attending r death. ector: After by the fune	atior	1 ☑ Natural 5 ☐ Per 2 ☐ Accident inv	ending (Month, De vestigation	ay Year)	Inju		k? Yes 2 □ No				
2	r Atte ter dea irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	ould not be etermined 28e. Place of in building, e	jury - At ho tc. (Specif	me, farm	street, factory, office		28f. Location (S City or To	Street a vn, Stat	nd Number or Ru 'e)	ural Route Number,
ָ	pital o		29a. Certifier 1 Cert	tifyIng Physiclan: To the best	of my kno	wedne d	eath occurred at the til	me date and place	and due to the	causel	s) and manner as	stated
:	To the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medi	ical Examiner: On the basis of and manners	of examina	tion and/o	or investigation, in my o	opinion, death occu	urred at the time,	date ar	nd place, and due	e to the cause(s)
1	vithir To th	Me	29b. Signature and title of cer	rtifier / /	1 /	,	29c. Licens				ate signed (Monti	h, Day, Year)
	5		La	mane of f	ndle	inl		00 30/2	2	- 7	1-7-07	
10	' '		/	rson who completed cause of				308 "	Ta	,	nd 21.	204
	Sta	te	31. Date filed (Month, Day, Y	(ear) 32. Regist	rar's Signa	ture	osler Dr	700	10WOON		MUC & la	<del></del>
	Registr		NUV	A T 2 COOL Day	H. Good	and william	1					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KEFFER **Physician** BEUFORD 23:28 PM NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 1 Yes 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1^{Year)}1937 **Funeral** Months Days 233-58-2758 1 XM 2 ☐ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 S. NEWKIRK ST. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify ģ Specify: WHITE 3 → Widowed 4 □ Divorced 'natural", er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) MACHINIST MACHINERY Department of Health and Mental Hygis Important: If item 27 is marked other I any injury or other traumatic event, it once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN KEFFER MACIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SERINA DUVALL/DAUGHTER 316 S. NEWKIRK ST., BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/26/07 | Baltimore, Maryland Metro Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, with only one cause on each line. 23a. Part Ener the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Physician -Z DAYS /Medical Due to (or as a consequence of) Examiner TOXIC MEGACOLON 5 DAYS Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed CLOSTRIDIUM DIFFICILE INFECTION 1-2 WEEKS Due to (or as a consequence of) 人式长 MU vision or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2**X** No npatient 1 🔲 Yes 2 ER/Outpatient 3□ DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Funeral TECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 24 and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of M.D. RES 000 NOVEMBER 1, 2007 141 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE, MARYLAND 20224 GIFFORD M.D. 31. Date filed (Month, Day, Year) State NOV 1 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month L'HHe 6:40 Physician Jimmie 2007 12 /Medical 4b. City, Town, or Location of Death 4c, County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Medical Center Baltimore Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs last birthday) 9. Birthplace (State or Fpreign **Funeral** 12 M 2 F Davs Director Phryary Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: δ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) lath Father's Name (First, Middle, Last) Mother's Name First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Batto. IND 21229 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Baltimore ☐ Other (Specify) 4 □ Donation 21. Signature of HLTONPASS BALTO MO ease, or complications that caused the death. Do not enter the mode of dying, ure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Partt F ter ne diseas shock or h art failure. such as cardiac or respiratory arrest. Immediat Carse (Final disease or ndition resulting in death) **Physician** meumonia /Medical Due to (or as a consequence of): **Examiner** Anoxic Brain Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner i or Attending Physician: The law requires that the death certificate be executed after death.

Intercor. After this certificate has been signed by the attending physician and Director. After this certificate see a should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certific 29c. License number P21190 November 12th 2007 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Ballimore, MD 2120 Parker 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND 111-14/20, perPHYS., 38/3, 11/13/07, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day}O 2007 **Physician** Ervin M. Lang Nov. 2:00 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Yrs. 216-22-8904 Director 76 22,1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or iteme 23e or 28a-f ehos other treumstic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Carroll Hampstead 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4220 Maple Grove Rd. Funeral 21074 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

XXVes 2 □ No
If Yes, Give.
Year of Detes 2 − 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Black & Decker and Mental Hygier is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob O. Lang, Sr. Nettie Winand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 ment of Health a ant: If Item 27 is Janet Lang - wife 4220 Maple Grove Rd. Hampstead, Md. 21074 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) njury or Department Important: If any injury or Black Rock Ch. Cem. Nov. 14,2007 Broadbecks, PA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 1. Hall Celles 3296 Charmil Dr. Manchester, MD. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Intarction immediate /Medical Due to (or as a consequence of): Examiner percholesterolemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physicien and should be detached for use as the burial-transit death certificate be executed Oronary Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification; 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 | Homicide within 24 hours e To the Funeral L 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ţ 29b. Signature and time of 29c. License number 50036112 s of person who completed cause of death (Item 23a) (Type, Print) 4231 Northwoods Trail, Hampstead, MD 21074 D.A. Rocha, M.D. 31. Date filed (Month, Day, Year) NOV 1 3 32 Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Sister Roselle Lintner Nov. 8, 2007 4:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1525 Marriottsville Road Marriottsville Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 F F 90 200-05-5448 9/16/1917 Director PA. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Marriottsville 1 ☐ Yes 2 No MD Howard Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21104 1525 Marriottsville Rd. Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: \$ 3 Widowed 4 Divorced white Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laboratory <u>lab technician</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Marie Gross William Lintner ပ္ 21104 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Anna Mae Crane, Pers. Rep. 1525 Marriottsville Rd., Marriottsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/07 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. nedral Cem. 22. Name and Address of Facility Sterling Ashton Schwab Witzke FH of Catonsville, Inc. Catonsville, Md. 21228 21. Signature of Fugeral Service Licensee of Catonsville, Catonsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosc 1erotic **Physician** ardiovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Disease **Examiner** Sequentially list conditions, if any, feading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760. physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the state of detached f 2 No Division or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 2 The law requires abetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Osteparthritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2□ No 1 | Yes 1 ☐ Yes Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Dalean Salahudden D20252 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D. Salahuddin, M.D., Northwest Hospital, Old Court Rd., Randallstown, MD 31. Date filed (Month, Day, Year) 3. Registrar's Signature State NOV 1 3 2007 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ernest Logan 11 6 2007 4:10p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5136 Darien Rd. Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 215-28-7230 Director 8-12-1934 Md Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f show aminer must be notified at 1X Yes 2 □ No Director Baltimore NA Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 5136 Darien Road traumatic event, the Medical Examiner must Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 TYPes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify Specify: Black þ 3 Widowed 4 Divorced 'natural', Completed permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany or other traumatic exercises." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sparrow Point Cement Operator 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hamlette ٧. Louise Logan U. Ernest 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5136 Darien Road, Baltimore, Md. Wife Lachita Logan 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □Burial 2 □Cremation 3 □Removal from State 4 □Dopation 5 □Other (Specify) 11-14-07 Owings Mills, Md. Garrison Forest Vet 22. Name and Address of Facility f Funeral Service Licensee 21. Signature March F.H. East 23a. F. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoc or heart failure. List only one cause on each line. 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death Im nediate Cause (Final di ease of condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of) physician Physician/Medical the l certificate SS attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1∐ Yes Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

Box 68760, P.O. | Division or Vital Records, ospital or Attending I hours after death.

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: filled in by

OH

State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifie

29a. Certifier

Charles Kind AssociateProfesso of Oncolog

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DC061040

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print 401

MD 21271-2410 (John Hospit

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature, 12 138 1

and manner stated.

			-	pe or Print in				_		
			For State Registrar	State of Maryla				Mental Hyg	giene	00010
					Cei	rtificate of I	Death	2. Date of Dea	Reg. No. 2	3. Time of Death
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Charles H. Long					Month	Day Year 2001	1
	Examin		4a. Facility Name (If not institution, give str	A 1	TOAL	4b. City, Town, or	Location of Deat	th DE	4c. County of Dea	th
		46	5. Social Security Number 6. Sex	AN HOSP	L I II	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	1 9. Bir	thplace (State or Foreign
	Funeral Director			M 2⊠F 89	s. last birthday) Yrs.	Months Days	Hours Min		(Year) Cr	land
	yland low at		10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	cto	Maryland	Bal	timore					1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	s 23a nust I	eral	5620 Knell Avenue	2. Was Decedent Ever in	118 13	21206	lispanic Origin? (	Specify Yes or No-	USA 14. Race - Ame	erican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ∐Yes 2₺No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	Specify:	rto Rican, etc.)	Black, White	te, etc.
Maryland 21215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade	ition	I (Give	dent's Usual Occup	during most of wo	orkina I	16b. Kind of Business	/Industry
21	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired asing Age	d)		Electronics	Company
2	filed w Hygie other th	S	17. Father's Name (First, Middle, Last)		rurene	ising nge			Maiden Surname)	
and	d be f ental   ced of	To Be	Henry Long				Sarah W	ilson		
ary	should and Men marke	F	19a. Informant's Name/Relationship (Type	e. Print)	I				er, City or Town, State,	Zip Code)
	and 2 salth a 1 27 Is er tra		Dolores Long (Wife)	)	5620	Knell Av	e. Balti			
altimore,	Pages 1 and 2 lent of Health nt: If item 27 I iry or other tra		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		Place of Dispo cemetery, cre 11aney	osition (Name of matory or other pla Valley	11-1	Date 3-2007	20c. Location - City of Maryland	Town, State
Balti	permit. Pages 'Department of I Important: If ite any Injury or ot		21. Signature of Funeral Service License	RuneRe		2. Name and Addre			Funeral Ho m, Maryland	
			23a. Part1. Enter the list-ase, or complice shock, or heart f M re. List only one	ations that caused the de	eath. Do not en	ter the mode of dyi	ng, such as cardi	ac or respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Y FAI				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):			4-110	V B DEFAR	
lit.	Lxammer	_	Sequentially list conditions, b.	Due to (or as a cons		RUCIIVI	E- 1061	TONAR	Y DISEAC	1
T	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	PAITINH	DAITE	1				
°.	be executed sician and burial-transit	Exal	resulting in death) Last	Due to (or as a cons	,	200 750 200				
3760,	ite be iysicia ne bur		L _d .	CONGES	STIVE	HEAR	FAS	LURE	-	
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0	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time o 9 □ Unknown	or death 5	Other (specify)_				
<u>α</u>	ires that the de signed by the a l be detached t		Part II. Other significant conditions conf	ributing to death but not i	resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	quires n sigr uld be	d by	HYPERTENSI	ON dia	betty,	Corona	ry	10	Yes 2□No 3□F	Probably 4 Unknown
Vital Records,	aw require s been sig 2 should b	Completed	artem disease				J	24a. Was	an 24b. Were a	autopsy findings available completion of cause of
Ä	sician: The law certificate has l irector, page 2 s	E O						perfo	ormed? death?	1
/ita	cian: ertifica	Be	25. Was case referred to medical examiner?			Tax		eath Check onl	one	
or/	> .07 0	P	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital: 11 Inpatient 2	28b. Time	ent 3 L DOA		1	dence 6 Other (Sp	ecify)
E C	ling After une	ion	1 ☐ atural 5 ☐ Pending	(Month, Day Year		Wo	rk? ]Yes 2∐No	Zou. Describe	now injury occurred	
Division	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of injury - A	t home, farm, s			28f. Location (	Street and Number or I	Rural Route Number,
Ö	al or a after at Director	erti	4 Homicide determined	building, etc. (Spe	ecity)			City of Tol	wii, Siate)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical (	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or i	ath occurred at the t investigation, in my	ime, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and manner a date and place, and d	as stated. ue to the cause(s)
	To the within 2	Me	29b. Signature and title of certifier			29c Licen	se number		29d. Date signed (Mon	nth, Day, Year)
				MN		KE	000		NOVERSE	R12, 2007
	10		30. Name and address of person who could be seen and address of person who could be seen a seen and address of person who could be seen a seen and address of person who could be seen a seen and address of person who could be seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a seen a s	11 2011	Item 23a) (Type	Print) HAN NBLU	D BA	LTINOR	REMD2	1232
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Cart !				
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DHMH 17 Rev 1/2001

			For State Registrar	State of Mary	land / Dep Ce	partment of I	Health and M Death		ene 2007 1. No.	36217		
767			Decedent's Name (First, Middle, Language)	ast)				2. Date of Death	<u></u> _	3. Time of Death		
	Physici		CATHERINE	REGINA LOCK				November	9, 2007	10:50 A ^M		
	/Medio		4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of Death		4c. County of Deat	h		
- 45			PICKERSGILL			Tows	on		Baltimore	County		
	Funeral Director		215-16-1306	1 DM 2ME	n yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	^(ear) 1923 Ma:	nplace (State or Foreign untry) ryland		
	land ow It		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits		
	Mary I-f sho	tor	Maryland Baltimon	e County		Towson				1 □Yes 2 No		
	ith the	Direc	10e. Street and Number	,		10f. Zip Code	24.007	100	g. Citizen of What Co	untry?		
	ath w	ral	532 A Stevenso				21204		USA  14. Race - American Indian,			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S.	i. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🎇 No	Hispanic Origin? (Specian, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, White, etc.  Specify: White			
21215-0036	ithin 72 ho ne. nan "natur s Medical I	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5+)	(Gin		pation during most of workind)	ing 16	Sb. Kind of Business/			
	lled w lygiel her ti nt, the	ဒ္	10th  17. Father's Name (First, Middle, Las	*)	Ho	omemaker	18. Mother's Name	(First Middle Ms	Own Resid	ience		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	Christopher Ed	ward Goldbec			Katheri	ne Regin	na Schaffeld			
Mar	d 2 sh th and 7 Is m traum	1 3	19a. Informant's Name/Relationship	(Daughter)	1	-			City or Town, State, 2 erville, N			
	1 and 2 Health tem 27 I	1 16	Louise A. Lock 20a. Method of Disposition			position (Name of rematory or other pla	Oc. Location - City or					
<u>o</u> E	Pages nent of I int: If ite		1 X Burial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec			d Mem. Pat	rk 11/12	2/2007 B	altimore,	Maryland		
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signal of June 1 Service Constitution D. La	huron		00 Managed Add			HOME, INC. Maryland			
-	No.		23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that caused the	death. Do not e					Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	ja.		6	ctive lu	"		Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):			J				
	<u>s</u>	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or, injury that initiated events	b. Due to (or as a oc	onsequence of/							
oʻ.	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):							
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x 68	entifica ling pl e as t	Med	IF FEMALE:									
.O. Box	The law requires that the death certifica ite has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	B Ectopic pregnanc D Other (specify)	су		23d. Date of del Month	ivery Day Year		
Δ.	s that ned b	by Pr	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
ıdş	w requires been signe should be	ed b	Cengestive	Heart	Jack	ine,		1 ☐ Yes	2 No 3 Pr	obably 4 Unknown		
Records,	sician: The law requisions: Sertificate has been irector, page 2 should	Completed	District CMCER, Ceronmy  24a. Was an autopsy performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed? Death of the performed									
Viital		BeC	25. Was case referred to medical				26. Place of Death	h (Check only one)		2 □ No		
or V	> .0 0	P.	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ent 3□ DOA Ot	her: 4 Nursing Ho	me 5 Residen	ice 6 Other (Spe	cify)		
o uo	ding h. After fune	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yo	ear) 28b. Time Injury	/   Wo	ıry at ork? ] Yes 2 □ No	28d. Describe how	v injury occurred			
Division	al or Attend affer death. I Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ro State)	ural Route Number,		
	To the Hospital or Attend within 24 hours affer death To the Funeral Director; completely filled in by the	Medical C		rhysician: To the best of n nminer: On the basis of ex and manner stated	amination and/or							
	To the within To the comple	Ě	29b. Signature and title of certifier	1.0	1440		se number		d. Date signed (Mont			
	Δ		Ill Hath	of Mily	1	102	5205		Vovembe	2,2007		
	6		30. Name and address of person who	completed cause of deat	h (Item 23a) (Typ	e, Print)	0 0:	0 1-	1	2 - 2 45		

State Registrar DHMH 17 Rev 1/2001

				partment of Health and Mertificate of Death		ene 2007	35218
	Dhuaisia		Decedent's Name (First, Middle, Last)		2. Date of Death Month	n Day Yeer	3. Time of Death
	Physicia /Medic		DOLORES ANTOINETTE LOSS		NOVEMBE		10:45 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	n
			723 Bedford Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Bel Air  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Harford 9. Bird	nplace (State or Foreign
	Funeral Director		217-26-0970 1□M 2⊠F 77 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Mar. 11	, 1930 Mar	vintry) v1and
	D		Usual Residence of Decedent				
	arylar ehow	-	10a. State 10b. County 10c. City, Town of				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Me	Directo	Maryland Harford Bel A	10f. Zip Code	10	ng. Citizen of What Co	
	with is or	급	723 Bedford Road	21014		USA	orray.
	death	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame	
ဖွ	or Ite		Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ∑ No If Yes, Give	1 ☐ Yes 3 ☐ No Specify:	rican, etc.)	Black, White	
LOSS 21215-0036	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:			W.	nite
NP	"nat	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation live kind of work done during most of work le. DO NOT use retired)	ina	16b. Kind of Business/ Plastic Pa	
212	withi ene. then	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	tory Worker		Manufactur	
	other vant,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	Aaiden Sumame)	
4 10	Menta burked artic e	10 E	Joseph (nmn) Buczek	Frances	(nmn)	Pytel	
Maryland	2 sho			ailing Address (Street and Number or Rur		•	(ip Code)
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	}	20a Mathod of Disposition 20b. Place of D			D 21014 20c. Location - City or	Town, State
وَ جَ	eges ant of t: If It		1 Burial 2 Remation 3 Removal from State cemetery,	or Service Corp. 11-	15-07	Baltimore,	MD
Baltimore,	ait. Poertme		21. Signature of Funeral Service Lipensee	22. Name and Address of Facility McComas Funeral Hor		Dar Children	
ä	Depermine Depermine Brown ir ir once		Mule a Ema L	1317 Cokesbury Roa	d, Abing	don, Maryl	and 21009
			23a. Part 1. Enter the disease, or complications that, aused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	lung Cancer			Onset and Death  Months
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)				
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ords	w require been sig should b	ted t	C.O.f.D.		1 XY6	es 2 No 3 Pr	obably 4 \(\begin{array}{c}\text{Unknow}n\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
ecc	law re	Completed			24a. Was a autops	n 24b. Were au	itopsy lindings available completion of cause of
<u>=</u>	sician: The law s certificete hes t lirector, page 2 s	Соп			perform 1 Yes 2		2 <b>N</b> O
V its	ician certifi ector	Be	25. Was case referred to medical examiner?  Hospital:	Other	th (Check only on		
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	o the ithin 2 o the omple	Med		29c. License number	2	9d. Date signed (Mont	h, Day, Year)
	F 3 F 8		1. o h. Shoper and	D28628		Now. 1	0. 2007
	~		30. Name and address of person who complete cause of death (Item 23a) (T	/pe, Print)		/ / / /	/
_	10		Carol G. Hoopen m.D. 133	D38638  (pe. Print)  N. Bridge St, E	Ikton,	MD. 2	1921
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	Physic /Med Exami	ical
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e Maryland	a-f show tified at	ctor

	•	For State Registrar	Olato o	i wai yiai		rtificate			Re	eg. No.	0 1	3021	_
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Physicia /Medic		Alexander	Leakan						Novembe	r 7, 20		2:00 A	М
Examin	er	4a. Facility Name (If not institu	-	mber)				tion of Death		4c. County			
	4	8904 Lincoln 5. Social Security Number	Street 6. Sex	7. Age (In yrs.	last hirthday	If Under 1	vage	nder 24 Hrs.	8. Date of Birth	Howa		lace (State or Fore	ian
Funeral Director		218-24-0874 Usual Residence of Deceden	1 <b>X</b>	7. Age (m yrs.	Yrs.	Months		urs Min.	(Month, Day, Dec. 26		PA	ntry)	
land bw		10a. State 10b. Cou	inty	10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Lim	its
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with the 3a or 28a	I Director	10e. Street and Number	Street			10f. Zip C	ode <b>32102</b> 20763		11	Og. Citizen of V		ntry?	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 0  3 Wildowed 4 0 Divor	Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formation Armed Formatio	2 □ No ive		Was Decede If Yes, specif 1 ☐ Yes 💥			ecify Yes or No- Rican, etc.)		ck, White,	ean Indian, etc. ite	
Maryland 21215-0036 d 2 should be filed within 72 hours aff tith and Mantal Hygiens, ar Is marked other than "natural", or r traumatic event, the Medical Exami	Completed	15. Dece (Specity only hi Elementary/Secondary (0-1	dent's Education ghest grade completed)	1-4or 5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupation done during retired)	most of worki	ing	16b. Kind of B	usiness/In	dustry	
d with giene ar tha	mo.	12th	2		Ca	ble Sp	licer			C&P	Tele	phone	
al Hyg	BeC	17. Father's Name (First, Mid	die, Last)				18. 1	Mother's Name	(First, Middle, I	Maiden Surnar	ne)		
/lag	ToE	Alexander	Leakan					Cecili	a Levi	cke			
and I sama	1	19a. Informant's Name/Relat	ionship (Type. Print)		19b. Maili	ng Address (	Street and N	lumber or Rura	al Route Number	, City or Town,	State, Zip	Code)	
and and a salth	l J	Marie Anne Fi	ncham/Daugh			. Box			ge, MD	20763			
Baltimore, ermit. Pages 1 ar Department of Hea mportant: If item any Injury or othe ance.	Ĭ	20a. Method of Disposition 1 ☐ Burial 2 【ACremat 4 ☐ Donation 5 ☐ Other		State	Place of Dispo cemetery, cre st Aru	ndel C	rem.	11/13	/2007	20c. Location Odent	on, l	MD	
Balti permit. Departi Importa any Inji		21. Signature of Funeral Ser	1008/20	OK M01	103 3	13 Tal	bott i	Avenue,	aldson : Laurel	, MD 2	Home 20707	e, P.A.	
Physician	6	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cau. (Final disease or condition	e, or complications that List only one cause on	caused the deat each line.	th. Do not en	ter the mode	of dying, su	ch as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):			LODID					
Laminer	ايا	Sequentially list conditions,	D	Respira		ailure							
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68760, 5 trificate be executed g physician and as the burial-transit	cal Examiner	that initiated events resulting in death) Last	c	(or as a conseq	quence of):								
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Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	¹ 1□Live	itcome pf pregn: birth 2 □Feta nant at time of d nown	al death 3	□Ectopic pre □ Other (spe					ate of deliv	ery Day Year	
P.O that the ed by the detache	Phy	Part II. Other significant cor	nditions contributing to	death but not res	sulting in the	underlying car	use given in	Part I.	23e. Did to	bacco use con	tribute to 1	the cause of death?	,
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hysic his ce	To	1 ☐ Yes 2 ☒ No			] ER/Outpatie		Other: 4	☐ Nursing Ho	me 5 <b>∑</b> Resid	ence 6 □Ot	her (Speci	ify)	
ion o nding Pl th.: After the funera	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pe 2 ☐ Accident inv	ending 28a. Date (Mo. ) erstigation	e of Injury nth, Day Year)	28b. Time Injury	of 28	c. Injury at Work? 1  Yes	2 □No	28d. Describe h	ow injury occu	rred		
Division or Vital Records, To the Hospital or Attending Physician: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:		termined 28e. Place	e of injury - At h ding, etc. (Speci	iome, farm, s	treet, factory,	office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rui	al Route Number,	
To the Hospital within 24 hours a To the Funeral completely filled	Medical C		tifying Physician: To the ical Examiner: On the and ma										
To the Within Fo the	Me	29b. Signature and title of ce	rtifier	_		29c.	License nu	mber	2	29d. Date sign			
		1 /w-	a 1/2-	/, M.	D		D0064	183		11/-	7/0	7.	
		30. Name and address of pe	rson who completed car	se of death (iter	m 23a) (Type				Suite	212			_
12		Sarah Be	enjamin, MD			ittle	Patux	ent Par	kway, C		, MD	21044	
Sta		31. Date filed (Month, Day,	(ear) 32.	Regionar's Sign	ature	Local	0						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician eague 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NIA alion Extended Care Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 1, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) Social Security Number **Funeral** 1 M 2 □ F Months 1946 Maryland Aug 215-46-5973 61 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Director Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.a 1233 Glyndon Ave. 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) soldier U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Mary League James ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 Glyndon Ave. Balto. Md. 21223 Susan Cole (companion) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐Removal from State Bayview Crematory 11/12/07 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 pamerous or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final ardnona **Physician** unkuown disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2[] No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manper of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 34359(OHiO)

State Registrar

31. Date filed (Month, Day, Year)

NOV 1

DHMH 17 Rev 1/2001

ORIGINAL

Raven Boulevard, Bastimore, Maryland 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3900

Loch

32. Registrar's Signature

07-08558

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

558 :- 1-:4-1 :441	-i-br	State of Maryland / Department of Health and N	Mental Hygie	ne	0	007 000		
ia Inita Little		For State Control of Programmer For State Certificate of Death	,,,	Reg. N	10	007 362		
Dhyminia		eqistrar . Decedent's Name (First, Middle,Last)	2. Da	ite of Death	y Year	3. Time of Death 1526 hrs		
Physicia Examin		Celia Inita Littlejohn		onth Da vember 3,	2007			
		ia. Facility Name (if not institution, give street and number)  335 Furrow Street  4b. City, Town, or Loc Baltimore			4c. County of Dea			
Euroral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		Date of Birth (N	M/DD/YYYY) 9. B	irthplace (State or Foreign ountry)		
Funeral Director		5. Social Security Number 215-86-4856 6. Sex 7. Age (In yrs. last birthday) Months Days 7. Age (In yrs. last birthday) Months Days 7. Age (In yrs. last birthday)	Hours Min.	Nov. 8, 1		FL		
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any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits  1 Yes 2 No		
		MD Baltimor	re			41		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 8.78 marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 102 S. Willward Street 2	1223	10g.	Citizen of What Co USA	ountry?		
th the 23a o notifi		Lac Was Decedent of Hispa	anic Origin? ( Specify	Yes or No-		erican Indian, Black,		
th wir	uneral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, N	uban, Mexican, Puerto Rican, etc.)					
or it	교	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No 3	specify:		Specify:	American		
s afte	<u>ā</u>	or Dates:	n (Give kind of work	done 1	6b. Kind of Busines	ss/Industry		
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with with giene her t	E O	17. Father's Name (First, Middle, Last)	8.Mother's Name (Fir	st, Middle, Ma	iden Surname)			
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212 ould be Menta mark ic even	O B	19a. Informant's Name/Relationship (Type, Print).  Twocrecia Littlejohn / Sister  1 south Fulton.						
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Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		638 M Cilmo						
T		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	such as cardiac or re	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending this infantial. It main	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  1 Ves 2 No 9 ✓ Unknown  1 Ves 2 No 9 ✓ Unknown	Ectopic pregnanc		23d. Date of de Month	Day Year		
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	completely		.M.E.					
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To the Ho within 24 P	COIL	30. Name and address of person who completed cause of Jestin (Item 23a)	;.M.E.	. MD 2120	_ <b></b> )1			
To the Ho within 24 P	COL	Thooken M. To & Thurs O.C.	;.M.E.	e, MD 2120	)1			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ANDREW MILLER 2007 RUBERT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOWARA COLUMBIA COUNTY GENERAL HOSDITAL HOWARD If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Sept. 16, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 **X**M 2 □ F 1931 Maryland 218-28-7730 76 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21043 5001 Avoca Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1948 If Yes, Give 11. Marital Status 1 ☐ Never Married 2 Married 1948-1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 1952 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Lieutenant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma Elizabeth Hefner Robert Paul Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5001 Avoca Avenue Ellicott City, MD 21043 (wife) Agnes Ann Miller 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veterans Cem. 11-19-2007 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature o Funeral Service Acensee 5555 Twin Knolls Road Columbia, MD 21045 Approximate Interval Between Onset and Death 23a. Part1. Et er the disea e, r com shock, or heart failure. List only caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 6 HOUR INTRACRAMIAL HEMORRHACE Due to (or as a consequence of): YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBSTRUCTIVE PULMON-1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown PROSTATE CANCER, CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? DISEASE, HYDERLIPIDEMIA 24a. Was an autopsy perform 2 No 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

**Physician** /Medical Examiner

certificate be exec

law requires that

or Attending Physician:

Box 68760,

P.0.

Division or Vital Records,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

r 28a-f show notified at

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other

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permit. Pages 1 and 2 sk Department of Health and Important: If item 27 is n any Injury or other traun

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

Exami Physician/Medical

Completed

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Certification: To

Medical

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of pertifier

sician and burial-transit the as attending nse for been signed by the should be detached has

24 hours after death Hospital within 24 hor To the Fune completely f

funeral After

State Registrar

10	i Lampationt 2	Tri o a chariour of		- 4	I real sing in	one series e Estate (epselly)
5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	- 1	Injury at Work? 1 ∐ Yes		28d. Describe how injury occurred
6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fa	actory, of	fice		28f. Location (Street and Number or Rural Route Number, City or Town, State)
1 Certifying Ph 2 Medical Exam	ysician: To the best of my kniner: On the basis of examin	owledge, death occ ation and/or investig	urred at t gation, in	he time, d my opinio	late and place on, death occu	, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number 138296 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8186 LARK BROWN RD, SWITE 201, ELKRIBGE, MD 21075 GIBBOUS MD 32 Registrar's Signature

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a, PtI, II, 25, 27e, 28e afe perpensing 874, 12/20/07 1. Decedent's Name (First, Middle, Last) Physician Joseph Mathe 11 2007 avid Nov /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harview Hvenue Parkville altimore Birthplace (State or Foreign Country) If Under 1 Year 6. Sex. 1 M 2 ☐ F Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 214-90-9176 -13-1961 Director maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show notified at 1 ☐Yes 2 No Director 28a-f altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 1-Ivenue Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify ģ white 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Heidtman 1St permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville Md 21236 Harview Avenue Mathew - moth Mary Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

EUCUS FUNERAL Chapel

*Cremation Syrs—Belgir 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Svrs-Parkville
Evans Funeral Chapel & Cremation Svrs-Parkville
8800 Harford Road Parkville Md 21234 21. Signature of Funeral Service Licensee S nautu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician dendentindue presumed /Medical disense Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine DEFINE ATTOM APPROVED EN APPLY ALL MANUER and burial-trar Due to (or as a consequence of) Box 68760. physician certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 I Inknown 9∏Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 21 No 3 ☐ Probably 4 ☐ Unknown Hypertensive Atherosclerotic 1 ☐ Yes Completed page 2 should Cardiovascular Disease, Obesity 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 □ No 25. Was case referred to m examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2 Certification: To this 28a. Date of Injury (Month, Day Year) Found: 11/11/2007 At hom-building, etc. (Specify) 28b. Time of Injury Wo 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 1 Linknown 27. Mann Death funeral 28c. Injury at Work? 28d. Describe how injury occurred he Hospital or Attending P n 24 hours after death. he Funeral Director: After t pletely filled in by the funera After t mural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2X Accident Unknown 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Found: 2919 4 ☐ Homicide Found: Home Harview Ave., Parkville, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 180/ York Rd. # 300 TOUSM MD 21204

State Registrar 31. Date filed (Month, Day, Yea) 0

32. Registrar's Signature

			1 - State Registrar	State of Mary		artment of F <i>rtificate of</i>		Mental Hy	/giene Reg. No20(	17	36224
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of D	eath Day	Year	3. Time of Death
-	/Medic Examin	al	Francisco 4a. Facility Name (If not institution, give		Z	4b. City, Town, o	r Location of Death		10 200 4c. County of		11:36a [™]
	Funeral Director		Bayview John 5. Social Security Number 6. St 134-32-1412 Usual Residence of Decedent		n yrs. last birthday) 66 Yrs.	Balt If Under 1 Year Months Days	imore If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Counti	ace (State or Foreign ry) rto Rico
	aryland show d at	Į.	10a. State MD 10b. County	10	c. City, Town or Lo	imore				10	d. Inside City Limits
	the Ma 28a-f notifie	Director	10e. Street and Number		Dail	10f. Zip Code			10g. Citizen of W	hat Count	1 Yes 2 □ No
	ath with		512 S. Lehigh				224		USA		
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub My Yes 2☐ No	dispanic Origin? (Span, Mexican, Puerto Specify: Pue		14. Race Black icanSpecify:	- America K, White, e	tc.
1215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. It other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired 1ice	during most of work	king	16b. Kind of Bus		·
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Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispo cemetery, crer Bayview	sition (Name of matory or other place Cremato	ory 11/	Date 14/07	20c. Location - 0	City or Tow	vn, State
Ball	permit. Page Department Important: If any injury or once.		21. Signature of uneral Service Licen	and	22	2. Name and Addre	ss of Facility 30 Ly Funer	00 Mac	e Ave.	Balt	O. MD
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	nted north	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a so	fisaquenea ol):						
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O. Box	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mon	of deliver	y Day Year
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Vital Records,		Completed	BENAL INSUFFIC	IENCY				24a. Was auto perfi 1 Yes	opsy propried? pr	rior to com eath?	sy findings available pletion of cause of
VITA	Physician: r this certificaral director,	Be	25. Was case referred to medical examiner? 1 ∑ Yes 2 □ No	Hospital:		t 3 DOA Oth	26. Place of Deat		one)		
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DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - building, etc. (S		eet, factory, office		28f. Location ( City or To	(Street and Numbe wn, State)	r or Rural	Route Number,
	ne Hospi 124 hou ne Funer sletely fill	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phy 2 Medical Exam	rsician: To the best of my iner: On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred at the tir vestigation, in my c	me, date and place, ppinion, death occur	and due to the red at the time	e cause(s) and mar , date and place, a	ner as sta nd due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
1	4	-	total S Oll 30 Name and address of person who c	ompleted cause of death	(Item 23a) (Type	) 006			NOVEMBE.	2/2,	2007
le	1 0		Heter S Greene	M.D. 10 H	Signature	AZA Bri	HITIMORE	MA 6	71201		
	Sta Registra		31. Date filed (Month, Day, Year)	2007 January	olynature .	meles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10-30 AM 9th 2007 November Alfred Floyd Mullins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 **X**M 2 □ F Virginia Aug. 31, 1937 70 Director 225-40-4124 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 ☐ No Director Aberdeen Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 7 must be n 21001 **USA** 5 East Aztec Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ral", or Items ? Examiner mu Black, White, etc. 72 hours after 1 Never Married 2 X Married 'natural", or 1 ☐ Yes 2 XNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Auto Manufacturer Welder 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F If item 27 is marked or other traumatic ev Nannie Bertha Keel Clintwood (nmn) Mullins Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 5 East Aztec Street, Aberdeen, MD 21001 Patsy J. Mullins/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ê 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once, Baker's Cemetery 11-13-07 Aberdeen, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign tun of Fundral Service License 22 Name and Address of Facility MCCOMAS Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DECLINE **Physician** FUNCTIONAL 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner months AILURE . THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Data to (or as a consequence of) Examiner EMPHESEMA EARS END STAGE burial-tran Due to (or as a consequence of): physician a Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performe 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident To the Hospital or Attent within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20056607 Nov. 9, 2007

State Registrar JOSEPH

31. Date filed (Month, Day, Year)

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602 S. ATWOOD Rd, # 205 BELATE, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regional's Signature

ANGELO

State of Maryland / Department of Health and Mental Hygiene

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FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listers of the list that initiated events resulting in death) Last	b	Due to (or as a consequence of):						L.	
1   Yes   2   No   3   Name and address of person who completed cause of dealth (Light grain)   24b. Were autopsy findings away prior to completion of cause death?   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes   XXNo   1   Yes	death cer e attendir d for use		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XXNo									
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   Family	quires that n signed b	þ	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause give	en in Part I.					
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   Family	The law rec te has beel age 2 shou	omplete			<del></del>			autop perfo	psy prmed? d	rior to com leath?	pletion of cause	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and the discussion of death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  D 39190  November 12, Z (0)  30. Name and address of person who completed cause of death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  29a. Certifier (Check only one)  29c. License number  D 39190  November 12, Z (0)  31. Date filed (Months Park, Year)  32. Date filed (Months Park, Year)  32. Date filed (Months Park, Year)												
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and the discussion of death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  D 39190  November 12, Z (0)  30. Name and address of person who completed cause of death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  29a. Certifier (Check only one)  29c. License number  D 39190  November 12, Z (0)  31. Date filed (Months Park, Year)  32. Date filed (Months Park, Year)  32. Date filed (Months Park, Year)	or Attending after death. Director: Afte in by the fune	rtification	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	on 28e. Place of injury	/ - At home, far	M 1 🗆	Yes 2 No			er or Rural	Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Riley, M.D. 3418 Olandwood Court, Suite 111 Olney, Maryland  31. Described (Months Park, Year) v. 32. Described (Months Park, Year) v. 32. Described (Months Park, Year) v. 33. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. D	Hospital 24 hours Funeral tely filled		(Check only 2 Medical Exa	ı <b>miner:</b> On th <b>∉</b> basis of e	xamination and	, death occurred at the til d/or investigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Riley, M.D. 3418 Olandwood Court, Suite 111 Olney, Maryland  31. Described (Months Park, Year) v. 32. Described (Months Park, Year) v. 32. Described (Months Park, Year) v. 33. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. Described (Months Park, Year) v. 34. D	o the o the o the o the omple	Mec		-AA	1/	29c. Licens	e number		29d. Date signed	(Month, E	Day, Year)	
30. Name and address of person who completed cause of death them 23a) (47pe, Print)  Joseph Riley, M.D. 3418 Olandwood Court, Suite 111 Olney, Maryland  31. Destried (Months Par. Year) - 32. Destriet and Signature	₽≥₽ŏ		) ( KHI	MAL	Al	D 39	190		Novemb	er 12	zin J	
31. Date filed (Months Pay, Year) 32. Requistrar's Signature	8						te 111 (				1 00 7	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

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		For State	Certific	cate of Death	Reg.	No.	01 0022
Physiciar ledical Examin	1/ 1	Decedent's Name (First, Middle, La	Montgom	2. Date of Death Month D November 8		3. Time of Death 2215 hrs	
	4	a. Facility Name (if not institution, g Good Samaritan Hospita	ive street and number	47. City, Town, or Location of Baltimore		4c. County of Dea	
Funeral Director	6	Social Security Number 6. 9	Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under  Months Days Hours  Yrs.	24Hrs. 8. Date of Birth	Fore	sirthplace (State or eign Country)
Maryland 28a-f show any d.at once,	<u>.</u>	Jsual Residence of Decedent  10a. State 10b. County  10c. Street and Number	Bo	n or Location  Himore  10f. Zip Code	10g	. Citizen of What Co	10d. Inside City Limits 1
r death with the N or items 23a or must he notifie	ial Di	1 Sheric 1 Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	1 Yes Z No	13. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican,  1 Yes 2 No specify:	Puerto Rican, etc.)	Specify: B	erican Indian, Black,
21215-0036 hould be filed within 72 hours after and Mental Hygiene. is marked other than "natural", tite event, the Medical Examiner	mpleted	15. Decedent's Education (Specify Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	. College (1-4 or 5+)	Decedent's Usual Occupation (Give k during most of working life. DO NOT to the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Co	ind of work done use retired)	Health aiden Surname)	& Care
, Mand 2 ealth : em 2 em 2 em 2 em 2 em 2		19a. Informant's Name/Relationship  20a. Method of Disposition  1 Burial 2 Cremation	M· Moore 20b. Place	9b. Mailing Address (Street and Num  203 Ching e of Disposition (Name of cemetery, latory or other place)	ber or Rural Route Numb	per, City or Town, Ste 20c. Location City	By To Man or Town, State
Baltin permit. P Departme Importan injury or	- 1	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic	ity: Kina	2 a and diress of Facility 1 and diress of Facility 1 and diress of Facility 1 and diress of Facility 2 and diress of Facility 2 and diress of Facility 2 and diress of Facility 3 and direct of Sacratic of Pacility 4 and direct of Sacratic of Pacility 4 and direct of Sacratic of Pacility 4 and direct of Sacratic of Pacility 5 and direct of Sacratic of Pacility 6 and direct of Sacratic of Pacility 6 and direct of Sacratic of Pacility 6 and direct of Sacratic of Pacility 6 and direct of Sacratic of Pacility 7 and direct of Sacratic of Pacility 8 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Sacratic of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility 9 and direct of Pacility	Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Greene Gr	Balk Figure Lto. M st, shock, or heart	Sorvices Abjuz Approximate Interval
Physician (aminer		failure. List only one cause on					Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b.  Due to (or as a consequence of):  c.  Due to (or as a consequence of):				
xecuted n and l - transit		events resulting in death) Last  UNPENDED	d			<u> </u>	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	sician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknot	23c. If yes, outcome of pregnan  1 Live birth  4 Pregnant at time of death	2 Fetal death 3 Ectopic	c pregnancy	23d. Date of deli	very Day Year
P.O. B es that the digned by the be detached		Part II. Other significant condition	and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	ting in the underlying cause given in Pa		2 <b>V</b> No 3	e to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death.  al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach	Completed by					sy prior	e autopsy findings available to completion of cause of h?  Yes 2 No
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner?		26.Place of Death			
Vit hysic rthis o	P	1 🗸 Yes 2 No	Hospital: 1 Inpatient 2 V EF	vouparion 1		Residence 6 C	Other:
Ing Pt After funeral	Ë	27. Manner of Death  1 ✓ Natural 5 Pendin	(Month, Day,Year)	3b. Time of Injury 28c. Injury at World 1 Yes 2		iow injury document	
Division of a To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	2 Accident Investign 3 Suicide 6 Could determ	gation 28e. Place of Injury - At home	e, farm, street, factory, office building, e			r Rural Route Number, City
To the Hospi within 24 hou To the Funer completely fil	dical	29a. Certifier (Check only one) 2 Medical Exam	sician: To the best of my knowledge, iner:On the basis of examination and/ and manner stated.	death occurred at the time, date and ploor investigation, in my opinion, death or	ccurred at the time, date	and place, and due	to the cause(s)
E N E S	Me	29b. Signature and title of certifier	1 0	29c. License number		29d. Date signed	
		Voujoure The	0 .000	MINCERTHO O.C.M.E.	· · · · · · · · · · · · · · · · · · ·	November 10	, 2007
57		Margarita Korell MD	no completed cause of death (Item 23 Assistant Medical Examiner		e, MD 21201		
s	ate	31 Date filed (Month, Day Year)	32 Registrar's Signature				
Regist	trar	NOV 1 3	2007 Bloken De	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			

			1 - For State Registrar	ate of Maryland	-	irtment of He tificate of L			ene 9. N2 0 0 7	36228
	Physici		Decedent's Name (First, Middle, Last)     GENEVIEVE	MALINOWSKI				2. Date of Death Month 11	Day Year 2007	3. Time of Death 11:23 p. ^M
	/Medic Examin		4a. Facility Name (If not institution, give stree 11630 GLEN ARM ROAD	and number) APT. 110		4b. City, Town, or	Location of Death		4c. County of Deatl	1
- 1 3 m	Funeral Director		5. Social Security Number 6. Sex 1 □ M	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/12/19	Year) 9. Birth	nplace (State or Foreign untry) TLAND
	aryland show d at		Usual Residence of Decedent  10a. State  10b. County	10c. City,	Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Ma 28a-f s notified	Director	MD BALTIMORE  10e. Street and Number		GLEN	ARM 10f. Zip Code		10	g. Citizen of What Co	**
	th with 23a or 1st be		11630 GLEN ARM ROAD	APT. 110			057		USA	,
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 □ Never Married 2 □ Married	Vas Decedent Ever in U.S. Armed Forces? □ Yes 2X No f Yes, Give		Vas Decedent of His Yes, specify Cubar ☐ Yes 2 KNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	, etc.
15-003e	n 72 hours I "natural" Iedical Ex	Completed b	15. Decedent's Educatio (Specify only highest grade co.	mpleted)	(Give I	ent's Usual Occupa kind of work done d OO NOT use retired)	urina most of work	sing	WI 6b. Kind of Business/I	HITE ndustry
717	d withi giene. er than the M	Somp	Elementary/Secondary (0-12)  8TH GRADE	College (1-4or 5+)		HOMEMAKER			OWN HON	Æ
aua	d be file intal Hy ed oth	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M PRZYBEK	laiden Surname)	
ary	should and Me s mark umatic	ြင	MICHAEL OCHAL  19a. Informant's Name/Relationship (Type. I	Print)	19b. Mailin	g Address (Street a			City or Town, State, Z	ip Code)
Š ď	l and 2 leaith a m 27 le		JOSEPH MALINOWSKI/SO			CHURCH RO.		TERSTOWN		
	ages lent of Hert. If ite		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Remode  4 □ Dongtion 5 □ Other (Specify)	ival from State		sition (Name of natory or other place SLAUS CEM	4		20c. Location - City or T BALTIMORE •	
Dali	permit. P Departm Importar any injur		21. Signature of Funeral Service Ucensee	- Ancism	22	. Name and Addres	s of Facility TH	E JOHNSON	N FUNERAL I	HOME P.A.
4	3 - 1 M		23 Pirt1. Enter the dise se, or corn lication shock, or heart failure. List only one care	ons that caused the death.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	ON, MD 2128	Approximate Interval Between
I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACUTE	; <u> </u>	WLMD	NABA	( CDE	MA	30minut
	Examiner	Je.	Sequentially list conditions, bb.	Due t (or as a conseque	M	MOLARD	IALJ	INFAR		30 minutes
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	CORDA	AR	9 AF	TER	21 G H	EASE	20 YEARD
00/00	ate be exe hysician a the burial-1	edical Ex	resulting in death) Last	Due to (or as a conseque		CLERO	212			EN YEARS
O. DOX O	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	f yes, outcome pf pregnand 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
UŠ, T	uires that signed by d be deta	by	Part II. Other significant conditions contributed by the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of t	MARCULI	AR	DIZER	F21/2	23e. Did tob	acco use contribute to	the cause of death?
necolus,	he law req e has been ge 2 shou	Completed	POLY MYAL	CIA R.	4-201	N ATIC	#	24a. Was ar autopsy perform	y prior to death?	topsy findings available ompletion of cause of
	ilan; T ertificate ctor, pa	Be Co	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes 2 th (Check only one	No 1 ☐ Yes	2□ No
5	ng Physic After this ce uneral dire	ို	1 ☐ Yes 2 No	1 Inpatient 2 E	R/Outpatien 28b. Time of Injury	t 3 DOA Othe	4 Li Nursing H	ome 5 Reside 28d. Describe ho	nce 6  □Other <i>(Spec</i> w injury occurred	cify)
JVISIOII O	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 s	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined 2	8e. Place of injury - At hom building, etc. <i>(Specify)</i>	ne, farm, stre		∕es 2 □ No	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	Hospital 24 hours a Funeral etely filled	Medical Ce	(Check only 2 Medical Examiner:	n: To the best of my knowl On the basis of examination						
	To the within To the compl	Me	29b. Signature and title of certifier	. Ma m Tagas la	m M	29c. License		29	od. Date signed (Month	n, Day, Year)
15	21		30 Name and address of person who compl KAM ANA (n OF A A	eted cause ondeathylitem 2	23an Type, I	Print) G GR	ioss Road	s #159	11/12/2 BALTIMA MJ 21	228
year.	Sta Registr	_	31. Date filed (Month, Day, Year)	32/Registrar's Signatu	Te San	all .				

injury or other permit. Page Department of Important: If any injury or once. **Physician** /Medical

Examiner

death with the Maryland

2 should be filed within 72 hours after n and Mental Hygiene.

Pages 1 and 2 ment of Health a

Baltimore, Maryland 21215-0036

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760

or Attending Physician:

death.

To the Hospital or within 24 hours af To the Funeral D

8521 Loch Raven Blvd.; Towson, MD 21286 23a Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final LILMONARE HRONIC RUCTIVE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 ☐ Fetal death 3 ☐Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Donknown 2 □ No 1 Yes 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 25 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending 1 ☐ Yes 2 □ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar SNEEM

31. Date filed (Month, Day,

Year)

NOV 1 3

SUITE 23

My STOOL

2835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland /8873 and ental Hygiene Certificate of Death 2. Date of Death 8 Day 1. Decedent's Name (First, Middle, Last) Physician 10:00 AM DOROTHY LEE **MYERS** 200 NOV. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A LEVINDALE HEBREW HOME BALTIMORE Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 😿 F 04707/1926 -26-7261 81 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov Examiner must be notified at 1 Y Yes 2 No Directo BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. I important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examinar months. 21215 U.S.A. 2500 W. BELVEDERE AVE. APT 218 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COSMETICIAN COSMETOLOGY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN **BRYANT** UNKNOWN UNKNOWN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 W. BELVEDERE AVE. APT. 218-BALTIMORE, MD 21215 MORTON MYERS / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE 11/09/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral-Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dementia Stag **Physician** 6 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANO Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cardiovascular 2 No 1 Tes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No ours after death.

neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier elulu. MD D0053928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA BELZUM 2434 WI BELVEDERE AVENUE BALTIMORE UD - 3

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year).

ORIGINAL

32. Registrar's Signature

			For State Registrar	State of Ma	ryland /		rtment			and M			2 N N	7	201	221
			Registrar     Decedent's Name (First, Middle, Land)	ast)		001	incate	OIL	Jealii		2. Date of Dea		<u> </u>		3. Time of	Death
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9	Examir		4a. Facility Name (If not institution, gi						Location of	f Death			County of			
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	w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							10	Od. Inside Ci	itv Limits
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E.	fter de r Item Ilner n	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give						gin? (Spo i, Puerto	ecify Yes or No- Rican, etc.)		Black, 1	White, e	etc.	
ENS 036	ours a ral", o Exam	þ	3 Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1	I□Yes 2	X No	Specify:				Specify:	WHI	ΓE	
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L A	iid be filed within 72 hours after death with the Marylar fental Hyglene. ked other than "natural", or Items 23a or 28a-f show ite event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las	t)		D	AVEN		18. Mothe		(First, Middle,	Maiden	Surname)	νF	LRICK	
ExELY Maryland	2 should be and Mental Is marked of aumatic ev	욘	JACOB  19a. Informant's Name/Relationship	(Type Print)	10			(Street s			al Route Numbe	r City o	r Town St			
BE:	and 2 s ealth an n 27 Is i		WARREN MORGANS						ROAD		al Route Numbe LTIMORE					
T0 more	Pages 1 ient of H nt: If ite iry or ott		20a. Method of Disposition  1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Spec	☐Removal from State	20b. Place cemes OHEB S	HALO	sition (Nam natory or of PARK	her plac	e) 1		/2007		Cation - Cit			
SAID TO BE Baltimore, I	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Lice	ensee H	MEMO	22	. Name and	d Addres		်	OL LEVI					
S	(5.5.24)		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused t	he death. Do	not ente	8900 er the mode	REI:	g, such as	cardiac	ROAD - or respiratory ar	PIK rest,	ESVIL	LE,	Approximat Interval Bet	
	Physician		Immediate Cause (Final disease or condition								- Dis		ro		Onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or as a										- F		
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Box 68760	death certific attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p 1 ☐ Live birth 2		th 3	Ectopic pr	eanancy					23d. Date o		*	
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10.	iding Phys h. : After this funeral dir		27. Manner of Death	28a. Date of Injury (Month, Day		. Time of Injury		Bc. Injury Work		irsing Ho	28d. Describe h			(Specii)	9	
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Division or Vital Records,	al or Att	Certification:	3 Suicide 6 Could not lead to determine determined		y - At home, (Specify)	farm, str	eet, factory	, office			28f. Location (S City or Tox			or Rura	Route Nun	nber,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of aminer: On the basis of and manner state	examination a	ge, death and/or in	occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date and	and mann d place, an	er as st	ated. the cause(	s)
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			> Karen L.,	Salit, M.	D.			1)0	2286	76		WW	5N P 1	- 9	,200	7
_	10		30. Name and address of person who Karrn Babit. 31. Date filed (Month, Day, Year)	completed cause of dea	ath (Item 23a	(Type,	Print)	oud.	sult	e 30	1 Bal	+ no	re, 1	10	2120	25
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DHMH 17 Rev 1/2001

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AMIN 11H#6, peri H, 081, 7/3/08, WS
State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFh, g874, 12/31/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 2007 8 DAVID MANDL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON 8. Date of Birth (Month, Day, Yea) 6. Sex 1 X M 2 V F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days Hours SĽÖVOKIA 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐Yes 2√ No Funeral Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21208 14 STONE PINE COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Medical Exa<u>miner mu</u> 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Saltimore, Maryland 21215-0036 WHITE Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GENERAL MANAGER TEXTILE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LITMAN MANDL JOLAN HENRY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14STONE PINE COURT - BALTIMORE, MD 21208 BLANCHE MANDL / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition CHEVRA AHAVAS CHESED 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/11/2007 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA DAYS **Physician** /Medical Due to (or as a consequence of): Examiner EBILITY Sequentially list conditions, if any sea ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9∏Unknown 9 D Unknown þ 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy performed 1 Yes 2 Molo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2**29**110 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t Natural 5 ☐ Pending investigation within 24 hours after .....
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 8, 2007 D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NCHARLESST SUITE 209 BALTIMORE, MD 21204 Ø DANIEUE DOBERMAN, MO 2. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 3 2007 Registrar

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 6:30 A M Margaret Darlene Nazarenus 2007 Nov 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 301 Clyde Ave. Lansdowne Baltimore 8. Date of Birth (Month, Day, Year 2, 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) if Under 1 Year | if Under 24 Hrs 5. Social Security Number 6. Sex 1 □ M 2 🔀 F Months Days 219-50-0235 Hours 1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10h County Baltimore 1 ☐ Yes 🎾 No Lansdowne 10g. Citizen of What Country? United States 301 Clyde Avenue 10f. Zip Code 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian Black, White, etc. 1 ☐ Yes 2 X if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Thiele Margaret Norene Chambers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Nazarenus - Husband 301 Clyde Avenue, Lansdowne, MD 21227 20b. Place of Disposition (Name of Meacles of Lage Metrior 1al Park 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 11-10-2007 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Approximate Interval Between Onset and Death

Hear

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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Completed

Be

MD

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Me. It. I Examiner must be notified at

3altimore, Maryland 21215-0036

**Physician** /Medical Examiner

executed

pe

Division or Vital Records, P.O. Box 68760,

Examiner burial-transit and physician Physician/Medical as the ed by the a 9 cate has been sig , page 2 should b Completed Be this funeral After Certification: spltal or Attendinours after death.
Ineral Director: /

23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) multi glioblastoma to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Wedical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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To the Hospital of within 24 hours at To the Funeral D

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role

a 31. Date filed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



07-08687 Dennis John O'Meara

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36235

eriiris soriir o iv	1	1- For State Certificate O		Reg. I	No	, 0020.
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		Date of Death     Month Da	v Year	3. Time of Death 1230 hrs
ledical Examir	ner	Dennis J. O'Meara		November 8,	2007	1230 nrs
		4a. I active Name (if not institution, give out of all its institution)	4b. City, Town, or Location of Death Bay Bridge	1	4c. County of Death Anne Arundel	
		Chesapeake Bay  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth(N	MM/DD/YYYY) 9. Birti	nplace (State or
Funeral Director		d. Social Sociality Manager	Months Days Hours Min	1.	Foreign	1
Bilector	-	219-64-1394 1XM 2 F 52 Yrs	5.	11/09/1	954 L	MD
ń		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	tion			10d. Inside City Limits
daryland 28a-f show any d at once.		MD Anne Arundel Glen Burn	iΔ		Ì	1 Yes 2 No
arylan 8a-f s	왌	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	itry?
ith the Maryland 23a or 28a-f sho notified at once	Director	406 A 7th Avenue N.E.	21060		USA	
with 1 ms 23s		A most States	as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
death or iter	Funeral	1 Never Married 2 Married 1 V Yes 2 No		o recent, occ.,		· + -
0036 within 72 hours after death with the Maryland siene. her than "natural", or items 23a or 28a-f sh. Medical Examiner must be notified at once	2	O District.	Yes 2 No specify:  nt's Usual Occupation (Give kind of	work done	Specify: Wn	ite
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	most of working life. DO NOT use ref	tired)	, , , , , , , , , , , , , , , , , , ,	
36 nin 72 than dical	Completed		ed Clinical Socia	al Worker	Counsel	or
	칡	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Mai	den Surname)	
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be (	John R. O'Meara		L. Wheatl		
D 21215-0036 should be filed within 72 land Mental Hygiene. 7 is marked other than "I natic event, the Medical Entire than "I natic event, the Medical Entire Event, the Medical Entire Event, the Medical Entire Event, the Medical Entire Event, the Medical Entire Event, the Medical Entire Event, the Medical Entire Event, the Medical Entire Event, the Entire Event Entire Event Entire Event Entire Event Entire Event Entire Entire Entire Event Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire Entire	၉		ng Address (Street and Number or			
MD  nd 2 shc atth and m 27 is	1	Sean P. O'Meara/Son 2601  20a. Method of Disposition 20b. Place of Dispo	Hillcrest Ave	Parkvill Date 2	e, MD 2123 Oc. Location - City or	Town, State
Baltimore, MD 21215 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th		1 Burial 2 Cremation 3 Removal from State crematory or c	other place)			
imc. Pagement trant:	L	4 Donation 5 Other Specify: Metro Cr	ematory 11	/10/07	<u>Baltimore,</u>	
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral Service Licenses 22.	Name and Address of Facility St.	allings F	uneral Hom	ne, P.A.
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	111 Mountain Rd. the mode of dying, such as cardiac	or respiratory arrest	a. MD 2112 , shock, or heart	Approximate Interval
_⊸ /Medical		failure. List only one cause on each line.				Between Onset and Death
çaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	NOWING .			
		Sequentially list conditions, b				<del> </del>
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.				
is gla	хац	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
and and - trans	a E	d				<del> </del>
60, stee be executed and thysician and the burial - transit	Medical	UNPENDED AMENDED			23d. Date of deliver	\
376 ificate ig phy s the t			Fetal death 3 Ectopic pregi	nancy		y Day <b>Ye</b> ar
Box 687  e death certifice the attending p	sician	past 12 months?  4 Pregnant at time of death 5	Other (Specify)		1	
Bo e deat the at	Phys	1 Yes 2 No 9 Unknown g Unknown	alada a sa sa siyaa la Dari I	23e Did tob	acco use contribute to	the cause of death?
o.O. that the red by detach	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part i.			bably 4 Unknown
S, P.C puires that an signed and be deta	pa		<del>_</del>	24a. Was an		utopsy findings available
ords, aw requir as been s	plet			autopsy perform	prior to	completion of cause of
Rec The 1 icate bage	Completed			1 Yes 2	✓ No 1 Y	es 2 No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Be (	25. Was case referred to medical	26.Place of Death (Checkint 3 DOA Other; Nurs		esidence 6 🗸 Othe	er: Scene
f Vi Physic er this ral dir	2			28d. Describe ho	ow injury occurred	
n of liding Ph. H.: After t	io io	1 Natural 5 Pending FOUND:	1 Yes 2 ✔ No	Subject Jump	oed from Bay Bri	dge
/iSior r Attend ter death irector: n by the	cati	2 Accident Investigation Nov 8, 2007 1225 hrs 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.			ural Route Number, City
Divi	Certification:	Suicide 6 Could not be determined (Specify) Bay		or Town, Sta Chesapeake B	ate) ay, Annapolis, MD	
Hospi 4 hou Finer ely fil			curred at the time, date and place, a	nd due to the cause	(s) and manner as sta	ited.
Divis To the Hospital or ∧ within 24 hours after To the Funeral Dire completely filled in b	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation and an anomalier stated.	gation, in my opinion, death occurred	d at the time, date a	nd place, and due to t	he cause(s)
F 3 F 3	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
		C/ lus	O.C.M.E.		November 9, 20	JU /
5		30. Name and address of person who completed cause of death (Item 23a)	Ctract Baltimore MD 0400	11	_	
		Loo Control	Street, Baltimore, MD 2120			
S Regis	tate trar	# # A A A A A A A A	rould			
DHMH 17 Rev 1/2			IAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 9, 2007 Mary Eileen O'Connell  $11:45p^{M}$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Parkville Oak Crest Care Center

5. Social Security Number | 6. Sex | 7. Age If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 3 / 8 / 1916 7. Age (In yrs. last birthday) 1□M 2□F 215-07-2564 91 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No MD Harford Belair 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 Lancelot Lane 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. If Yes, Give ** Year or Dates: 3℃Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Larkin James Hines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael O'Connell/Son 606 Lancelot Lane Belair, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/07 Timonium, MD Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1050 York Rd Towson, MD 21. Signature of Funeral Service Licensee Mille Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Cancer unknown primar Due to (or as a consequence of): Sequentially list conditions, if any earling of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

a or 28a-f show t be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b

Baltimore, Maryland 21215-0036

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Box 68760,

P.0.

Division or Vital Records,

Director

Funeral

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Completed

Be

attending physician for use as the burial signed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

၉

Certification:

Medical

State

Registrar

Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 👿 No 9 Unknown Completed 25. Was case referred to medical examiner? Be

1□ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No 27. Manne of Death 1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

29b. Signature and title of certifier

1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Mi

November 10, 2007

Parkaille, und Z1234

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8000 walther

Anna Montas 31. Date filed (Month, Day, Year) NOV1 3

32. Registrar's Signature

07-08706 Timothy Player

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 36237

outy riayor		For State	Certifica	ate of Death	Reg. No		Time of Dooth
Physiciar dical Examin	1	Decedent's Name (First, Middle, Last)	thu PLa	iyek	2. Date of Death  Month Day  November 9, 2	Year 2007	Time of Death 0655 hrs
		a. Facility Name (if not institution, give since 1200 block of Pratt Street		4b. City, Town, or Location of De Baltimore		c. County of Death	
Funeral Director	5	. Social Security Number 6. Sex 2/8-62-3298 1 M	7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24 Months Days Hours M	Ars. 8. Date of Birth (MM	Foreign	ry) Md.
ом апу		Jsual Residence of Decedent  Oa. State 10b. County	10c. City, Town	or Location		[1]	Od. Inside City Limits  Yes 2 No
ne Maryland or 28a-f sh	Director	10e. Street and Number	st Rd.	10f. Zip Code 2   2   5	10g. C	itizen of What Country	1
death with or items 23 must be no	∟	1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No Yes, Give Year	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put  1 Yes 2 No specify:	( Specify Yes or No- erto Rican, etc.)	14. Race - America White, etc.	n Indian, Black,
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after de neur of Health and Mental Hygiene.  The filed I is marked other than "natural", or or other traumatic event, the Medical Examiner m	<u>a</u>	3 Widowed 4 Divorced 11  15. Decedent's Education (Specify only  Elementary/Secondary (0-12)	r Dates	Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	retired)	Temp,	ocies
21215-0036 uld be filed within 7 Mental Hygiene. marked other thar	Be Completed	17. Father's Name (First, Middle, Last)	Player	18.Mother's N	ame (First, Middle, Maid	en Surname).	ی
MD 2121 d 2 should be fi Ith and Mental n 27 is marked numatic event,	10 B	19a. Informant's Name/Relationship (Typ	yer- WIFE 1	9b. Mailing Address (Street and Number 1241 Washingtow of Disposition (Name of cemetery,	Bivo. Ba	City or Town, State, of Modern City or Town	, 21230
Baltimore, ML permit Pages 1 and 2 s Department of Health a Important: If item 27		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Specify:	Removal from State crem	atory or other place)	1-14-07	Lansda HILTON F	one, md.
	TA.	21. Si f Funeral Service Lice	_ 1	not enter the mode of dying, such as card	1 F.H. Ba	eto, ma.	
Physician 'Medical aminer		for ure. List only one cause on each immediate Cause (Final disease a.	h line	tic Cardiovascular Disease			Death
	Examiner	cause. Enter Underlying Cause	tue to (or as a consequence of):  Oue to (or as a consequence of):				
760, icate be executed physician and the burial - transit	Medical Ex	dunpended	AMENDED				
Box 68760, ne death certificate be true attending physic hed for use as the burned by the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned for the burned	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic p	regnancy	23d. Date of delivery Month E	Day Year
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the complete for the complete of the complete for the complete for the complete of the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the complete for the compl	by	1 Yes 2 No 9 Unknown Part II. Other significant conditions	9 Unknown contributing to death but not resul			oably 4 🗸 Unknown	
Division of Vital Records, tat or Attending Physician: The law requires as after death.  Director: After this certificate has been signed in by the timeral director, page 2 should by	Completed				24a. Was an autopsy perform	ed? prior to death?	otopsy findings available completion of cause of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon
Vital Rec ysiclan: The his certificate director, page		25. Was case referred to medical		26.Place of Death (0	Check only one)		
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ion of Virtending Physicath.  For: After this the funeral dir	tion: To	27 Manner of Death	(Month, Day,Year)	8b. Time of Injury 28c. Injury at Work?	No	w injury occurred	
Divisior To the Hospital or Attend within 24 hours after death To the Functal Director- completely filled in by the	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	be 28e. Place of Injury - At hom d (Specify)	e, farm, street, factory, office building, etc	or Town, Sta	ate)	ural Route Number, City
D To the Hospital within 24 hours To the Funcral completely fille	Medical	(Check only one) 2 Medical Examine	ian: To the best of my knowledge, r:On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occurred.	urred at the time, date a	nd place, and due to t	
	Ž	Coma moine		O.C.M.E.		November 9, 20	
3		30. Name and address of person who Donna M. Vincenti, MD	Assistant Medical Exami	ner 111 Penn Street, Baltimo	ore, MD 21201		
Regi	State	1101/7 9 //	32 Registrar's Signature	Booke			

OCME

			For State	State of Ma		ertment of H ertificate of L						
70	e s		Registrar  1. Decedent's Name (First, Middle, Las	st)	00	Timeate of t	Jeani	2. Date of Deat	h 2	07	3, Time of	eath A
	Physici		Frederick Pi	++man				Month i	Day :	Year	13/1	М
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County		•	
			Sinai Hospital	of Balt	imore.	Baltin	none C	144	N	/A		
	Funeral		Social Security Number     6. S	ex 7. Age IXIXM 2□F	(In yrs. last birthday	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or I	-oreign
ile.	Director		213-14-9990 Usual Residence of Decedent	KW ZDI	85 Yrs.			JUL 19			H CAROI	JINA
	and w		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City	Limits
	Mary f sho	ō	MADAL AND NI /A		R	ALTIMORE					1 DXYes 2	!□No
	r 28a	Director	MARYLAND N/A  10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?	
	th wit		3711 MARMON AVE	NUE		21	207		U.S	. A .		
	ems er mu	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spanic Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ		
36	or It		1 Never Married 2 Married	1XXYes 2 □ No If Yes, Give Year or Dates:4		1 □ Yes 2 <b>XX</b> No	Specify:		Specia	£		
5-0036	n 72 hours after death with the Maryland "natural"; or Items 23a or 28a-f show edical Ex miner must be notifled at	d by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed			edent's Usual Occup	ation		16b. Kind of B	DLA		
Ċ	in 72 "na" r	Completed	(Specify only highest gra	de completed)	(Giv	e kind of work done of DO NOT use retired	during most of work  )	ing	TOD. KING OF D	usiiiess/iii	dustry	
212	filed within Hygiene. other than " ent, the Med	E O	Elementary/Secondary (0-12)  10th grade	College (1-4or 5+		NTER			SHIPY	ARD		
פַ	at Hygin other vent, th	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Surnai	ne)		
<u>la</u>	ould be Mental arked o atic eve	ToE	unknown				ANNA	FREEMAN				
Maryland	and and is m		19a. Informant's Name/Relationship (	Type. Print)	19b. Mai	ling Address (Street a	and Number or Run	al Route Number	; City or Town	, State, Zip	Code)	
			Winifred Johnson	Blagmon/Dau		3711 Marmo						
0	Sign		20a. Method of Disposition 1 ☐ Burial 2 ★★ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cri	ematory or other plac		Date	20c. Location	- City or To	own, State	
altimore,	it. Pa rtmen rtant: njury	i	4 □ Donation 5 □ Other (Specify	·		REMATORY	11-1:				MARYLAN	ID
Ra	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer	ISEE .		22. Name and Addres WILLIAM C L206_W_NOR			FUNERA:	L HOM	E P.A.	
	ý		23a, Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do not er				est,	li	Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	. Mul		arct De	mentia			- 1	Onset and De	eath
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						3 2007	
	Examine	<u>.</u>	Sequentially list conditions, if any leading to immediate	b.								
<u>a</u>	ted sit	nine	Cause (Disease or injury	Due to for as a	conse uence of :							
7v.	execu and al-trai	Examiner	that initiated events resulting in death) Last	CDue to (or as a	consequence of):					-		
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X Q Q	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		□Ectopic pregnancy				ate of delive	,	
	ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5 Other (specify)					Month Day			ear
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Vital Records,			25. Was case referred to medical				00 Pl ( P )	1 Yes	2000	1 ☐ Yes	2 <b>□</b> No	
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0	g Phys er this eral dir	-	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time	of 28c. Injur		28d. Describe ho			y/	
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Division	r Atte ler de irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Num n, State)	ber or Rura	al Route Numbe	er,
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	To the Hospital or Attending Physician: which 24 hours after death.  To the Funeral Director: After this certification in the funeral director, to the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director director, and the funeral director director, and the funeral director director director, and the funeral director director director, and the funeral director, and the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director direct	edical		ysician: To the best of niner: On the basis of and manner stat	examination and/or							
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}			Comple	M.D.		RES	-000		Novem-	ber	9+4 20	000
	141		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	e, Print)			7			
			31. Date filed (Month Day, Year)	M. U.	DINGU Signatura	HOSP-		_			_	
A .	Sta Registr		NOV 1 3 200	7 Registral	J. S. S. S. S. S. S. S. S. S. S. S. S. S.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1&29c State of Maryland / Department of Health and Mental Hygiene 11/13/0/JH Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alice Betsy Phillips 12:34 PM Month Physician Phillips No vanie 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Opper Cheseceake Medical Jr. Age (In yrs. la Baltimore Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖼 213-26-872 Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 Yes 2 No Completed by Funeral Director WD Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A Sorbus Court 2104 1313 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 2 No 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Blac K 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hyglene." rs
7 is marked other than "ns Elementary/Secondary (0-12) College (1-4or 5+) Pastor Churc 18. Mother's Name (First, Middle, Maiden Surname) and 17. Father's Name (First, Middle, Last) Be Williams Saluda <u>Kenneth Williams</u> P Baltimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley Phillips/Daughter
20a. Method of Disposition Health i 1313 Sorbus Court Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Daurial 2 □ Cremation 3 □ Removal from State un Cemptery 11.10.2007 Baltimore, MD 22. Name and Address of Facility Voughn C. Greene Funeral Services Woodlawn Cemptery! 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4905 York And Baltimore, MD 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) minute Chmic Physician /Medical equen Examiner スと Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 9☐Unknown Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I á 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? yes 2XNo After this certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient P Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the nooppear within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier vovember 2007 H0053869 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person - Chesipech Madical Center 2. Registrar's Signature Natunya 31. Date filed (Month, Day, Year) State NOV 1 3 2007

DHMH 17 Rev 1/2001

Registrar

301284008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9 2007 Pirog Mary Nov 7 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Baltimore N/A If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)

Jan 18,1919 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months 1 ☐ M 2 🛛 F 217-01-9375 88 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 XIYes 2 □ No **Funeral Director** MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1214 S. Street Potomac 21224 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Clerk Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Chester Koluch Maryanna Nowakowska 19a. Informant's Name/Relationship (Type. Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Pirog-Quarles 1214 S. Potomac Street Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-15-07 4 Donation 5 Dother (Specify) Holy Rosary Cem. Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or lach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 ☐ Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 Hospital or Attending Physician: director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter t Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death e Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

completely

within 2 the

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DHMH 17 Rev 1/2001

29b. Signature and title of certifle

person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

TELLI. MID 1218. EATON St. BILLT.

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Rawlings Viola 11 07 2007 5:15a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore Inc If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 TF 91 Director 214-12-4987 10 10 16 MD Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> Baltimore 1X Yes 2 No Director MD MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21225 Funeral 2413 Terra Firma Road #25 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker House 8th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cora Johnson James Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4911 Ivanhoe Ave, Baltimore, Md 21212 Alvin E. Rawlings-Son Pages 1 8 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 11/12/07 Arbutus, of Funeral Service Licensee 22. Name and Address of Facility March F/H West 3a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Baltimore, Md Immediate Cause (Final iso se or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Š been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cont vute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1∐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 6 Dother (Specify) After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniurv 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: the Funeral Director: Af within 2

> State Registrar

4 Homicide

(Check only

29b. Signature and title of certifier

(ear)

1 3

onth, Day,

29a. Certifier

and manner stated.

l 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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2007

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		State of Maryla	and / Depa	artment of Hea	alth and Me	ental Hygi	ene	
		1 - State Registrar	Ce	rtificate of De	ath	Re	g. No.2007	36243
Physicia	an	1. Decedent's Name (First, Middle, Last)				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
/Medic	cal	Lawrence M. Rogers	Sr.	4.00 -		11	10 200	
Examin	er	4a. Facility Name (If not institution, give street and number)	101.	4b. City, Town, or Loc	ation of Death		4c. County of Dea	
Funeral			vrs. last birthday)		Under 24 Hrs.	8. Date of Birth	Baltin 9. Bir	1000 thplace (State or Foreign
Director		181-14-8368   ¹☑M 2□F	86 Yrs.	Months Days H	ours Min.	B. Date of Birth Month, Day March6	921 _{Wes}	t Virgini
pug M		Usual Residence of Decedent           10a. State         10b. County         10c.	City, Town or Lo	ocation				10d. Inside City Limits
Maryle f shored	ō	MD Baltimore		altimore				1 ☐ Yes 2 XNo
28a- notifi	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
h with	al D	7 Whitelaw Place		21236			USA	•
within 72 hours after death with the Maryland lene. Itan "natural", or Items 23a or 28a-f show he Medical E-aminer must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto R	ify Yes or No-	14. Race - Ame Black, Whit	
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hour	ed b	3   Widowed 4   Divorced Year or Dates:	16a, Dece	dent's Usual Occupation	1	11	6b. Kind of Business	
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be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last) Hobart M. Rogers		18.	Mother's Name (			
d Men narke natic	2	19a. Informant's Name/Relationship (Type, Print)	101 11 7					
id 2 sl Ith an 17 Isr traur		Lawrence Rogers Jr. /so	on 170	ng Address (Street and I	e Drive	Belai	city or Fown, State, 2 .r MD 210	21p Code) 1 <b>1</b> 5
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Inmportant: If lem 27 Is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			b. Place of Dispo	sition (Name of	Da	ite 2	20c. Location - City or	Town, State
Page Tent o nt: If		1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐ Other (Specify)		matory or other place) s of Faith	n   11/1	4/07	Rossvill	e MD
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d d ansit	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 outit	is				
be executed ician and burial-transit		resulting in death) Last Due to (or as a cons	sequence of):					
cate be executed physician and the burial-transit	dical	d		-N-	<del></del>			
The law requires that the death certificate tite has i een signed by the attending phys bage 2 should be detached for use as the	Med	IF FEMALE:						
attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ F 4 □ Pregnant at time of the past 12 months?	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
the d y the ached	ysi	1 ☐ Yes 2 ☐ No 4 ☐ Fleghalt at time of 9 ☐ Unknown 9 ☐ Unknown	or deduit of					
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law ra as re 2 sho	Completed	<u> </u>				24a. Was an		utopsy findings available completion of cause of
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iclan: Sertific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:			Place of Death	Check only one	>)	
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th. : Afte : fune	tion	1 Natural 5 Pending (Month, Day Year 2 Accident investigation		f 28c. Injury at Work?  M 1 ☐ Yes		d. Describe no	w injury occurred	
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tal or s afte al Dir ed in	Certification:	4 Homicide building, etc. (Spa	еспу)			City or Town,	, State)	
4 hour		29a. Certifier (Check only 2 Medical Examiner: On the basis of exam	knowledge, deat nination and/or in	h occurred at the time, divestigation, in my opinio	date and place, ar	nd due to the ca	use(s) and manner as	s stated.
the thin 2 the thin 2 the thin 2 the the thin 2 the the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the thin the t	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. License nur			d. Date signed (Mont	
5 ¥ ₹ 8	-			P00\$503			1/10/4	n, Day, Tear)
1	1	30. Name and address of person who completed cause of death (I	Item 23a) (Tyne	5.0				
		Dr. Jacques Conoway 1 31. Date filed (Month, Bay, Year)  NOV 1 3 2007	4D.9000	Franklin Sa	LOTE Dai	ie, Rall	MAR MA	21237
Stat		31. Date filed (Month, Bay, Year) 32. Registrar's Signary	gnature	es .	and VIII	, will	unvilve(D)	~! ~ 3 /
Registra	ar	NUV 1 3 2007	.0 A					

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N 1 - State Amend #26 Per Verbal G873 11/13/97 JH Registrar	lental Hygie Reg	ene	07	36244
Ö	Physicia	ın	1. Decedent's Name (First, Middle, Last) Finley P Rey	2. Date of Death Month Vovember	Day	2 ⁸ 87	3. Time of Death 8,55 A M
)* 	/Medic Examin Funeral Director	er	4a. Eacliky Name (If not institution, give street and number) Baltimore Renabilitation and  Extended Care Center  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.    Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear)	9. Birthp	
No.	p		227-28-8679         80         11s.           Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	JULY J	1921		Od. Inside City Limits
	r 28a-f sh notified	Funeral Director	Maryland Cecil Perryville  10e. Street and Number 10f. Zip Code	10g	j. Citizen of	What Coun	1 ☐ Yes 2 🔯 No try?
	h with	<u>e</u>	63 Patterson Avenue 21903	US	SA		
9	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☐ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 ☐ No If Yes, Give  1 ☐ Yes 2☒ No Specify:	ecify Yes or No- Rican, etc.)		ce - Americack, White,	etc.
2-0036	72 hours "natural", dical Exa	Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	6b. Kind of E	VVII	ite dustry
121	within iene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Heavy Equipment Operat	1	U.S.	Gover	nment
nd	be filed tal Hygi d other	BeC		e (First, Middle, Ma	_	me)	
Maryland	should be nd Mental marked o	၉	Leonard (nmn) Ray Carrie  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru.	(	Jance City or Town	n. State. Zin	Code)
	1 and 2 sho Health and tem 27 Is ma wher traums		Carrie Ray-Murray/ Daughter 63 Patterson Ave., Pe		-		,
altimore,	S = = 0				c. Location		
<u>=</u>	permit. Page Department of Important: If any injury or once.	1	4 Donation 5 Other (Specify)  Mt. Zion U.M. Chr. Cem. 11  21. Signatur Finera Scriptce Licensee/		el Air	, Mar	yland _
Ba	Depart Impo		21. Signatur F nera San/te Licensee Program MicComas Funeral Ho		don, M	aryla	nd 21009
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Advanced Muttiple Infavction Due to (or as a consequence of):	or respiratory arres	intia		Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	al Examiner	Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of).				
O. Box 6	The law requires that the death certificate ate been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			ate of delive	ery Day Year
rds, P.	quires that n signed b ıld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use col		ne cause of death? pably 4 Unknown
al Records,	s <b>ician:</b> The law require certificate has been siç rector, page 2 should b	Completed			ed? No	were auto prior to co death? 1  Yes	psy findings available mpletion of cause of 2 12 No
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Division or	tending Phyeath. tor: After thi		27. Many of Death  1 Natural 5 Pending 2 Accident  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 38c. Injury at Work? 1 Yes 2 No	28d. Describe how			
Divis	al or Atte s after der al Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Nun State)	nber or Rura	ıl Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examiners and the time, date and place 2 Medical Examiners and death occurred at the time, date 2 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 3 Medical Examiners and death occurred at the time, date 4 Medical Examiners and death occurred at the time, date 3 Medi	rred at the time, da	te and place	e, and due t	o the cause(s)
)	To t with To t	Σ	29b. Signature and title of certifier  Heory E. Wills # 11,D. 29c. License number  D41365	N/	d. Date sign	ber	11 2007
	54		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Seorge & Wicks M D 3900 Loch Raven B	pulevard	BRE	timor	, MD 21218
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 1 3 2007  38 Registrar's Signature				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARY STREETT RIGGS 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16444 MARKOE RD. MONKTON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 1 F 214-22-7473 95 09/01/1912 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medi-al Examiner must be notified at 1 ☐ Yes 2 X No MD BALTIMORE MONKTON Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16444 MARKOE RD 21111 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2XNo Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No <u>م</u> Specify: WHITE 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) 12YRS College (1-4or 5+) BOOKKEEPER BOOKKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be WALLACE WARFIELD MARY STREETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant; If Item 27 Is 1 JACK FISHER (COUSIN) 2511 HOUCKS MILL RD. MONKTON, MD. 21111. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 11/10/07 BALTO. CITY, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address HENRY W. 16924 YOF Address of Facility W. JENKINS & SONS CO. YORK RD. MONKTON, MD. 21. Signature of Funeral Service Licenses aum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEBILITY **Physician** MONTHS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transi and Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy performed? has 1□ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3□ DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

death certificate be executed P.O. Box 687600 The law requires that the Division or Vital Records,

death

filed within 72 hours after

Saltimore, Maryland 21215-0036

or Attending Physician: within 24 hours after death.

To the Funeral Director: / Fo the Hospital

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

DANIELIE DOBERMAN, MO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565NEHARLES ST SUITE 209 BACTIMERE MD 21204

**ORIGINAL** 

16 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64395

29d. Date signed (Month, Day, Year)

NOVEMBER 9. 2007

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland /	Department of Certificate of		and Mental Hyg	giene Reg. N2 0 0 7	36246		
	Physici /Medio	_	Decedent's Name (First, Middle	e, Last) Lucv	R	elves		2. Date of Dea Month Novem	ath Yea			
	Examir	ier	4a. Facility Name (If not institution  Structure (I Zale)  5. Social Security Number	th Nursing 6. Sex 7. Age	n Cen	birthday) If Under 1 Ye		AMORE  24 Hrs. 8. Date of Birth	4c. County of De			
	Director		148-05-4411 Usual Residence of Decedent	1□M 2 <b>X</b> F	95	Yrs.	10013	Min. MOV 7	1912 Pe	nnsylvania		
	Marylar fed at	tor	MD Ba1	timore		Lethorpe				10d. Inside City Limits 1 ☐ Yes 2 1 No		
	with the	Direc	10e. Street and Number 5011 Tulip Ave			10f. Zip Cod	227		10g. Citizen of What	•		
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural" or items 23e or 28e-f ehow event, tre Medical Exercites must be coffied at	by Funeral Director	11. Marital Status  1 Never Married 2 Mar 3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No		13. Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ar Black, Wt	nerican Indian,		
21215-0036	s within 72 ho piene. r then "netu	Completed		t's Education st grade completed)  College (1-4or 5+	)	Sa. Decedent's Usual Oc (Give kind of work do life. DO NOT use re Honemaker	one durina mosi	t of working	16b. Kind of Busines Own Home	,		
Maryland		To Be C	17. Father's Name (First, Middle, Kristop Bro			_		r's Name <i>(First, Middle,</i> ette Erbe				
Man	d 2 sho th and 7 is m		19a. Informant's Name/Relations Artman Reeves					or or Rural Route Number Halethorpe	_			
	0 0		20a. Method of Disposition 1 DBurial 2 Commation		20b. Place ceme	of Disposition (Name of tery, crematory or other	f place)	Date	20c. Location - City	or Town, State		
Baltimore,	pernat. Pag Department Important: any njury o		4 Donation 5 Other (S			Crematory Crematic 299 Free	ddress of Facilit	ety of Mary Road, Balti	Baltimon land, Inc. more, MD	_		
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused to only one cause on each line.  Due to (or as a	Dei	n en fra				Approximate finterval Between Onset and Death		
68760,	Ite be executed ysicien and he burial-transit	Ical Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence	orexia	rtery	Disea	re	years		
P.O. Box 68	death certifica e attending ph d for use as th	Physician/Medi			IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 7 No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal dea				23d. Date of o	delivery Day Year
	quires that in signed b uld be deta	by	Part II. Other significant condition Peptic Mic	ens contributing to death but	. 0	g in the underlying cause	e given in Part I.	23e. Did to		lo the cause of death? Probably 4 Unknown		
Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed	Atrial 6	nsion Fibrillati	m			24a. Was autop perfo 1 🗆 Yes				
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2□ER/	Outpatient 3 □ DOA		of Death (Check only oursing Home 5 Resid		pecify)		
ion of	on Wite		27. Magner of Death  1 Natural 5 Pending investigations	28a. Date of Injury (Month, Day	281	D. Time of 28c. Injury	Injury at Work? 1 □ Yes 2 □	28d. Describe t	now injury occurred			
Division	al or Atte s after de il Directo ed in by th	Certification:	3 Suicide 6 Could 4 Homicide determ		y - At home (Specify)	, farm, street, factory, off	fice	28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,		
	To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completely filled in by the fi	Medical (	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner state	examination	dge, death occurred at the and/or investigation, in r	ne time, date an my opinion, dea	d place, and due to the th occurred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)		
	To t withi To ti	Σ	29b. Signature and title of certifie	220111	ro		cense number		29d. Date signed (Mo			
•	5		30 Name and address of person	12 7 7 7 7 17		a) (Type, Print)	,0 11	alt mure	Marila	nd 21227		
	Sta Regist		31. Date filed (Month, Day, Year,	100	en SGP r's Signature	& Sparker	nt 113	villining	v wy (w	nu cies		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 

/Medical Examiner

**Funeral** Director

r than "natural", or items 23a or 28a-f show the Mycical Examiner must be notified at .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant; If Item 27 is marked other th ijury or other traumatic event, the permit. Pages 1 and 2 s
Department of Health ar
Important: if Item 27 is
any injury or other trau

hours after death

within 72

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

certificate be executed burial-transit Division or Vital Records, P.O. Box 68760. attending physician the as use the ģ Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

3, Roland 2007 November Reeley, Sr. 12:15pm 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hospice of Baltimore & Howard Co. Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 M 2 □ F Months Hours 215-30-6812 July 14, 1934 Maryland 73 Usual Residence of Decedent 10c City Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director WV Jefferson **Kearneysville** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 231 Morningside Drive 25430 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 ☒ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction **Drywall** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Butts James Reeley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 231 Morningside Drive Kearneysville, WV 25430 Debra A. Reeley - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Gdns 11/9/07 Fredericksburg, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Covenant Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Onset and Death Immediate Cause (Final cell carcinoma Merkels inentho disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if an , leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? Yes 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Matural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 BMC 6701 N. Charles St. Balts. md 2120x 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 3 2007 Registrar

Please Type or Print in Black Indelible Ink.	Ensure All Conies Are Legible
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:15 P. M Bentha T. Robertson November 7 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Overlea Rehabilitation Center Baltimore Overlea 8. Date of Birth (Month, Day, Year) January 7, 1922 5. Social Security Number 220-14-2854 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours Min. Mary I and Director Usual Residence of Decedent 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore Maryland 1 TYYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3031 Westfield Avenue 21214 1ISA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 □ Yes 2 No Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Buck Mary Gorecki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Bialek/Companion 3031 Westfield Avenue Baltimore Maryland 21214 20b. Place of Disposition (Name of cemetery crematory or other place)
MOST HOLY RECECTORY 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/07 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHASTRIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the irrector, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 21110 eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 | Yes 2 | No 2 ER/Outpatient 3 DOA 4 Wursing Home မှ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) NOVEMBER 12, 2007 D0060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gr RIVER NECK PANKAJ KHETERPAL ZU BACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 2007 03:15 Р м Raymund Rosenstock /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCt. 24 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2□ F 37 300-72-3708 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 1 ☐ Yes 2 X No Anne Arundel Maryland Annapolis 10e. Street and Number 10g. Citizen of What Country? 21401 USA 612 Admiral Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify White δ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Computers permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeanette Conrov Nel son Α. Rosenstock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 680 C Street, Pasadena, MD 21122 Jeanette Meinhardt (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Date 12 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Sprrato disease or condition resulting in death) /Medical as a consequence f) Examiner pinom Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No page 2 s 1□ Yes 24 TNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 | Pendina 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Registrar

3

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) ...

2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 2007 36250 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** James Steckbeck 0417 AM 2007 4 Nov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **½**□M 2□F 182-30-0713 **Director** 25, 1939 68 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Director 1 □Yes 2 □ No Maryland Prince Georges Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8264 Imperial Drive 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black. White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Analyst 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Clement, Sr. Miriam Romig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. Catherine Maransky- sister 1200 N. 8th Street, Lebanon, PA 17046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitian Cremetory 11/8/2007 Alexandria, Virginia 21. Signature of Fune a Service Licensee 22. Name and Address of Facility Inh Fleck Funeral Home, INC M0123 7601 Sandy Spring Road, Taurel, MD 20707 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Intarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tra-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 √Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P19665 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Baltimore MD 21201 Tiffany Bridges 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 3 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2007 245 AM Stephen Michael Smysley Nov. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Laurel Regional Hospital Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F Months Days Hours Min. Pennsylvania 16,1919 88 577-40-9596 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 USA 15817 Wayne Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2K Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 42-45 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept of Defense College (1-4or 5+) Elementary/Secondary (0-12) Research Analyst NSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Justina Spulnick Michael Measley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15817 Wayne Ave, Laurel, MD 20707 Patricia Smysley- wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/8/2007 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitian Crematory 22. Name and Address of Facilit 21. Signature of Funeral Service Licensee Fleck Funeral Home, INC. 7601 Sandy Spring Rd, Laurel, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis E. Coli Due to (or as a consequence of): Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Prostate Cancer Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed and P.O. Box 68760. physician Records. page 2 Division or Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p

Examiner Physician/Medical Completed Be Certification: To Medical

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

death with the

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Funeral

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r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Examines

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

within 2 State Registrar

1 ☐ Yes 2 ☐ No 9 Tillnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer with Metatasis to Lumbar Spine <u> Anemia</u> <u> Acute Renal Failure</u> 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 → Natural 2 → Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

of certifie

29c. License number 00064986 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7300 Van Dusen Road, Laurel, Maryland 20707

31. Date filed (Month, Day, Year) NOV 1 3 2007

29b. Signature and time

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Norman Earl Smith	1- For State	State of Maryland / Dep	ertificate of De			200	7 3625
Physician/	Registrar		- anoate of De	-	2. Date of Dea		3. Time of Death
Medical Examiner	Norman		Sm	774	Month Novembe		0322 hrs
	4a. Facility Name (if not insti	tution, give street and number)		city, Town, or Locatio altimore	on of Death	4c. County of Deatl	h
Funeral	Social Security Number	·			nder 24Hrs. 8. Date of B		rthplace (State or
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tith the Maryland 23a or 28a-f show notified at once.	ais NE	918 N. Broadway		Timor f. Zip Code 2/2	15	4.5.	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was De	ecedent of Hispanic C	Origin? (Specify Yes or Notan, Puerto Rican, etc.)	0- 14. Race - Amer White, etc.	rican Indian, Black,
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212 ould be d Menta s marke it even To B	19a. Informant's Name/Relat		19b. Mailing Ad	dress (Street and N	Number or Rural Route Nu		e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by I	MACIETTA.		3008	RAYME			2/2/6
ore, ss I an of Hea If iter	20a. Method of Disposition  1 Burial 2 Crem	ation 3 Removal from State	. Place of Disposition crematory or other p	place)		20c. Location - City o	
Baltimore, permit. Pages I an Department of He Important: If ite	4 Donation 5 Othe	er Specify:	KEEN Mou	ATCem.	Nov 13, Zeo	* BATTION	or, Mi
Balti permit. Departr Import injury	21. Signature of Funeral Ser	vice Licensee	22. Name	and Address of Fac	sility nepri 1to	BAITE M	1.2015
Physician		e, or complications that caused the dea					Approximate erval Between Onset and
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Division tal or Attendir ars after death. "al Director: A lled in by the fu ertification	2 Accident 3 Suicide 6	Investigation 28e. Place of Injury - At	home, farm, street, fa	ctory, office building			tural Route Number, City
Division o Hospital or Attending 24 hours after death. Funeral Director: After telly filled in by the funeral death or the funeral death or the funeral death or the funeral death or the funeral death or the funeral contr	4 V Homicide	determined (Specify) Local Str	eet		or Town, 1000 North E	Broadway, Baltimore,	MD
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Ledical Certification: To Be Completed by Physician/Me	(Check only 1 Certifying	ng Physician: To the best of my knowle Examiner: On the basis of examination and manner stated.	-				
Me se se se se se se se se se se se se se	29b. Signature and title of ce	ertifier	<del></del>	29c. License numb	ber	29d. Date signed (M	
<b>-</b>	Candl	Hallan		O.C.M.E.		November 4, 20	JU /
31	Carol Allan, MD	rson who completed cause of death (Ite Assistant Medical Examiner	111 Penn Stre	eet, Baltimore, N	MD 21201		
State Registrar	110114	ear) 32 Registrar's Signa	ature Love	P			
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			For State Registrar	State o	f Marylan	d / Depa <i>Cer</i>	artment of H rtificate of L	ealth and I D <i>eath</i>	Mental Hygid	ene 200	7 36253
	Physicia	an	1. Decedent's Name (First, Midda Charlotte	fle, Last)	D.		Schmi		2. Date of Death Month November		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution				4b. City, Town, or		.1	4c. County of	
			Johns Hopkins 1 5. Social Security Number	Bayview Ge	riatirc 7. Age (In yrs.		Baltime If Under 1 Year	ore If Under 24 Hrs.	8. Date of Birth		NA  Birthplace (State or Foreign
	Funeral Director		213–18–0219	1 M 2 T√F		35 Yrs.	Months Days	Hours Min.	Feb. 16	1922	Maryland
	land ow It		Usual Residence of Decedent  10a. State 10b. County	у	10c. City	y, Town or Lo	cation				10d. Inside City Limits
:	Ba-fsh	Director	,	NA	Ва	altimor					1 Yes 2 No
:	3a or 2		10e. Street and Number 4940 Easter	n Avenue			10f. Zip Code 21224	4	. 10	g. Citizen of Wha	at Country?
	tems 2	Funeral	11. Marital Status	12. Was Dec			Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No- to Rican, etc.)		American Indian, White, etc.
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important; If them 27 is marked other than "natural", or items 23a or 28a-f show important; If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	If Yes. Gi	ve		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
2-0	n 72 ho "natur edical	Completed	(Specify only high	ent's Education lest grade completed)			dent's Usual Occup kind of work done o DO NOT use retired		rking 1	6b. Kind of Busin	ness/Industry
717	ed withing a set than er than the M	Somp	Elementary/Secondary (0-12)	College (	1-4or 5+)	_	amstress		Ma		Shirt Factory
	d be file	Be	17. Father's Name (First, Middle						ne (First, Middle, M		
ary	should and Me is mark aumatio	P.	C. Henr 19a. Informant's Name/Relation		Willia		ng Address (Street	Harriet and Number or Ru	ural Route Number,	M . City or Town, Sta	Schultz rate, Zip Code)
ŭ ŭ	1 and 1 Health em 27		Carol H. Pfeff	er ( Nied			C-6 3531 esition (Name of matory or other place			<del></del>	to., Md.21206
	Pages nent of ant; If It ury or o		1  Burial 2  □ Cremation 4  □ Donation 5  □ Other (		State		matory or other plac leart of .	1	165 2007 ² D	undalk.	Maryland
ספון	permit. Departi Importa any Inj		21. Signature of Funeral Service	e Licensee	· Pi				jnacki Fu	neral Ho	omes P.A.
			23a. art1. Enter the disease, shock or heart failure. Lis	or complication, that of	caused the deat	th. Do not ent	er the mode of dyin	alk Ave. g, such as cardia	Raltimor or respiratory arre	e, Maryl st,	1 and 21224  Approximate Interval Between
F	hysician /Medical		immediate Cause (Final disease or condition resulting in death)	_a. / B	ement		1				Onset and Death
	Examiner			Due to	(or as a consequence	quence of):	- NOS Harise				
1	ted nsit	Examiner	Sequentially list conditions, if any, reading to minimum actions cause. Enter Underlying Cause (Disease or injury	Due to	(bras a norsey	pushes off):					3.0
ý	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	c Due to	(or as a conseq	uence of):			_		
	ficate be physici s the bu	dical		d							
XOC	sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome pf pregna birth 2 ☐ Feta		∃Ectopic pregnancy	,		23d. Date	· ·
	the dea y the att ched fo	ysici	in the past 12 months? 1 ☐ Yes 2 [x] No 9 ☐ Unknown		nant at time of o		Other (specify)			Month	h Day Year
λ, T	es that gned by be deta	by Ph	Part II. Other significant condi	tions contributing to d	leath but not res	sulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
ecoras,	v requir been si should	eted	,						1 ☐ Ye	х	Probably 4 Unknown ere autopsy findings available
Ď Ľ	The lar ate has page 2	Completed							autopsy perform	/ prid ned? dea	or to completion of cause of ath?
VITA	slcian: certifica rector,	Be	25. Was case referred to medic examiner?	Hospital:		1==10	ot 3E DOA Oth	or.	ath (Check only one	;)	
0	ng Phys ter this neral di	on: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 X Natural 5 ☐ Pend	28a. Date	<u> </u>	ER/Outpatier 28b. Time o Injury	IL SU DOA	4 Ki Nursing i	dome 5 ☐ Reside 28d. Describe ho		
DIVISION	vttendli death. ctor: A y the fu	icatic	2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Coul	stigation d not be	e of injury - At h		M 1 □	Yes 2 □ No	28f. Location (Str.	eet and Number	r or Rural Route Number,
2	Ital or / rs after ral Dire led in b	Certification:	4 ☐ Homicide deter	rmined 206. Place build	ding, etc. (Speci	ify)			City or Tòwn	, State)	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		and mai	basis of examination	ation and/or ir	nvestigation, in my	opinion, death occ	urred at the time, da	ate and place, an	nd due to the cause(s)
	To th To th compl	Me	29b. Signature and title of certif	fier / /_		^	29c. Licens	e number	29	d. Date signed (	(Month, Day, Year)  12 9, 2007  Wd 21724
)	0		30. Name and address of person	on who completed cau	v nise of death (iter	m 23a) (Type.	Print)	5/6	3 //	ovembe	r 7, 2007
			Grace & Cov	rdts ma	5505	Hopki	ns Bay	View Cr	. Salt	none	Wd 21224
F	Sta Registi	ate rar	31. Date filed (Month, Day, Yea NOV 1 3	2007	negistrar's Sign	ature 1	and the same				ŕ

07-08646 Jame

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36254

es Stewart			or State	State o	n Marylanu /	Certifica	ate of l	Death			Reg. N	lo		
Physici		1. D		e (First, Middle,Last)						2.	Date of Death Month Da November 6,	y Year		Time of Death 2035 hrs
Exami				ay Stewar			- I Ar	City Town	, or Location of		November 6,	4c. County of	Death	
			Facility Name (it Harbor Hos	f not institution, give	street and number)		"	Baltimore					N/A	
Funeral		5. S	Social Security N	lumber 6. Sex	7. Age	e (In yrs. last bir	hday)	If Under 1			8. Date of Birth(N		Foreign	1
Director		22	20-92-16	1 90°	M 2 F	29	Yrs.	Months [	Days Hours	IVIIII.	Jun. 29	, 1978	Countr	y) MD
		_	ual Residence of			10c. City, Town	or Locatio	on .						d. Inside City Limits
w any		10a	a. State	10b. County  Anne Ai	rundo1	roc. Oity, romi		len Bu	ırnie				1	Yes 2 X No
yland n-f sho t once.	to	106	MD e. Street and Nu		Luidei			10f. Zip Co			1 - 3	Citizen of Wh		1
he Mar or 28:	Director			Jersey A	venue				21060			United		
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	la	11.	. Marital Status	771	12. Was Decedent		13. Was	s Decedent of es, specify C	if Hispanic Orig uban, <b>Me</b> xican	gin? (Spec , Puerto R	cify Yes or No- ican, etc.)	14. Race White		n Indian, Black,
death or iten	Funeral	1		ied 2 X Married	1 Yes 2	X No			No specify:			Specify:	Whit	te
s after rral",	<u>آ</u>	1 3	Widowed	4 Divorced		mpleted) 16a	Donodon	t'e Heual Oc	rupation (Give	kind of wo	ork done 1	6b. Kind of Bu	siness/Ind	ustry
1215-0036 d be filed within 72 hours after fental Hygiene. narked other than "natural",	Completed	-	Elementary/Sec		College (1-4 or				g life. DO NOT		1	Infra	Mota.	le
036 ithin 7 ene. or than	l au		12				ASS	sistan	t Super	r's Name (	First, Middle, Ma			1.5
15-0 filed w Hygic d othe	၂ ပိ			(First, Middle, Last) Stewart					Ch	narlo	tte Finn	erlv		
ID 21215-0036  Should be filed within 72 hours after and Mental Hygiene. Tis marked other than "natural", 12 is marked other than "natural", 12 in anzier event, the Medical Examiner.	To Be	19	9a. Informant's N	lame/Relationship (T	Type, Print )		9b. Mailin	g Address	Street and Nu	mber or Ru	ural Route Numb	er, City or Tov	vn, State, Z	Zip Code)
AD 2 shot In and 27 is	-	10		M. Stewa	rt - Wife				rsey Av	rennu	e, Glen	20c. Location	- City or T	own, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho		20	0a. Method of Di	cremation 3	Removal from S	State Meado	WP Pd	e pirane	orial	11_	12-2007			
Pages		4	Ponation	5 Other Specify		Par	3			ity Amb	rose Fu	neral F	Home,	Inc.
Baltimore, permit Pages I ar Department of Her Important: If ite		12	Signature of F	I Almi	M. M. DOGH	1 no/	$2 \times 2$	719 Ha	mmonds	Fry	Rd., Lan	nsdowne	∍, MD	21227
~ Physicia		2	3a. Part I. Enter	the disease, or com	plications that cause	ed the death. Do	not enter	the mode of	dying, such as	cardiac or	respiratory arres	st, shock, or h	eart	Approximate Interval Between Onset and Death
ledica	al	,	failure. List o mmediate Cause	only one cause on e e (Final disease a	Multiple Injurie									Death
amine			or condition resu	_	Due to (or as a cor	nsequence of):								
	3	5 10 11	Sequentially list of any, leading to	immediate	Due to (or as a cor	nsequence of):								
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68760, certificate be	the bu	Į Mė	IF FEMALE:	ent pregnant in the	23c. If yes, out	come of pregnar		etal death	3 Ecto	pic pregna	ancy	Month		Day Year
OX 6876 eath certificate attending phy	use as	ciar	past 12 mon	nths?	4 Pregnan	t at time of death		Other (Spec	ify)					/
Box e death of the atten	9		1 Yes 2	No 9 Unknow	9 OHKHOW		ilting in the	e underlying	cause given in	Part I.				the cause of death?
P.O.		ا اھ	Part II. Other si	gnificant conditions	s contributing to a	eath but not root	,	, ,			1 Yes			bably 4 Unknown
ds, Figures	uld be	ĘĘ									24a. Was		prior to	utopsy findings available completion of cause of
COFC law re	(4)	Completed										rmed? 2 No	death? 1 ✓ Y	es 2 No
Re I: The	or, pag		25 Was case re	eferred to medical					26.Place of De		only one)			
of Vital Records, ng Physician: The law requir Mer this certificate has been s	directo	o Be	examiner? 1 ✓ Yes	2 No	Hospital: 1 Inc	patient 2 🗸 E			OA Other		ing Home 5	Residence		er:
of Vital Recoling Physician: The law	filled in by the funeral director, page	-	27. Manner of E		28a. Date of (Month, I Nov 6, 20		8b. Time (	of Injury	28c. Injury at V 1 ✓ Yes 2		Subject str	ick by fork	lift	
vision or Attendi ther death.	y the f	atio	1  Natural 2 ✓ Accider	- I Citain	9	of Injury - At hor	ne. farm. s	treet, factory	-		28f. Location	Street and Nu	ımber or R	Rural Route Number, City
Division Septital or Attendit hours after death.	q ui pa	Certification:	3 Suicide	determi	not be	Warehouse	,, -				or Town, 4501 Curtis	State) Avenue , Ba	timore,	MD
E 2 2	ely fill		4 Homici 29a. Certifier (Check only				e, death or	courred at the	e time, date an	d place, ar	nd due to the cau	se(s) and ma	nner as sta	ated. the cause(s)
To the I	completely	Medical	$\times$ /	✓ Medical Exami	ner:On the basis of and manner sta	examination and	d/or invest	igation, in m	y opinion, deat	II occurred	at the time, date			fonth, Day, Year)
FIFE	3	Be	29b. Signature	and title of certifier	N			29	o. License num			Novemi		
				alabe	ena)		23.0\							
7			1	address of person worke MD. Ass	ho completed cause sistant Medical	e of death (Item) Examiner	23a) 111 Pe	enn Stree	t, Baltimore	e, MD 21	1201			
	Si	ate	at Division		2007 32 Bec	gistrar's Signatu	: 4	perki						
Po		trar		MONT	C001	لنكر المستيان للا	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 15 am laVin 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 740 West Poplar Grove St #9L Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**反**M 2□ F Months Days 220-18-9349 83 Director 20 24 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examiner must be I 21216 U.S.A. 740 West Poplar Grove St #9L Funeral 12. Was Decedent Ever in U.S. Armed Forces?

M☐Yes 2☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by Specify: Black Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lasting Paint Co. Paint Maker 10thgrade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eleanor Thompson John W. Scott Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 Is any injury or other trau once. 3009 W Lanvale Street, Baltimore, Md 21216 Margaret Williams-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 11/15/07 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mald March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disesse or condition ulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 25. Was case referred to medical examiner? certificate conol 1∐ Yes 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 ☐ Yes 8 No 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral ( 28a. Date of Injury (Month, Day Year) 27. Manger of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitai to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Description Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier HO064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linden Av. Baltonere ( MD 21201 927 Dr. Keuer CATHIS BULLEY 31. Date filed (Month, Day, Year) State 1 3 2007 Registrar

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		For State		S	tate of M	larylan	_	artment of			lental F	lygier	ne		
		State Registrar	- (F-1 14:44)				Cei	rtificate o	Death	7		Reg. I	vo. 2 (	107	36256
Physici		1. Decedent's Name Edward	ie (First, Middi	e, Last)				Sar	irre	1	2. Date of Month	[	Day	Year	3. Time of Death
/Medio		4a. Facility Name (/	If not institution	n, give stree	et and number	)		4b. City, Town			11	1	L ∠ 4c. County	007 of Death	1:35p. [™]
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Funeral		5. Social Security N	Number	6. Sex 1 <b>½</b> ∑ M			last birthday) Yrs.	If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of (Month,	Day, Yea		9. Birthp	place (State or Foreign
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with the	Funeral Director	10e. Street and Nur 5415 Jo		7,110				10f. Zip Code	2121!	5		10g. (		What Cou	•
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after or iter		1 Never Marr	ried 2□ Man		Armed Forces I ☐ Yes 2 ☐ f Yes, Give		-	Was Decedent of If Yes, specify Co			Rican, etc.)		Bla	ck, White,	etc.
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in 72 I	olete		15. Deceder cify only highe	st grade co.	mpleted)		16a. Dece (Give life.	dent's Usual Occ kind of work don DO NOT use reti	upation e during mo ed)	ost of work	ing	16b.	Kind of B	usiness/In	dustry
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, <u>the Medical Examiner must be notified at</u>	Completed	6th gra		1	College (1-4or na	5+)		etaile					Auto	Con	pany
be file tal Hy d othe	Be	17. Father's Name	(First, Middle,	Last)					18. Mot	her's Name	(First, Mid	dle, Maid	en Surnar	ne)	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 → Burial 2 4 → Donation			oval from State	•   '	Mt. Z	matory or other p <b>3 i o n</b>	i	11/1	5/07	В	alti	more	e, Mđ
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that the	Phy	Part II. Other signi:		ons contrib	uting to death	but not res	ultina in the u	nderlying cause	iven in Par	t I.	23e. D	id tobacc	o use con	tribute to t	he cause of death?
luires n signe lid be	d by	A .	CULA				-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Ves			pably 4 Unknown
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Atten r deal ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	not be	8e. Place of in	njury - At ho etc. <i>(Specif</i>	ome, farm, str	reet, factory, offic			28f. Locatio	n (Street	and Numi	ber or Rura	al Route Number,
tal or rs afte al Dir	Certification:	4 [] Tomicide			building, e	stc. (Specin	у)				City or	Tòwn, St	ate)		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier (Check only	1 ☐ Certifyii 2 ☐ Medical	ng Physicia Examiner:	On the basis	of examina	wledge, deat ation and/or in	h occurred at the vestigation, in m	time, date : opinion, d	and place, eath occur	and due to red at the tir	the cause	e(s) and m and place,	anner as s	stated. o the cause(s)
o the ithin 2 o the omplet	Medical	one) 29b. Signature and	d title of certifie	er.	and manner s	tated.		29c. Lice	nse number	r		29d. l	Date signe	ed (Month	Day, Year)
F 3 F 8		11		M.D											.007
3		30. Name and addr		who compl	eted cause of	death (Iten	n 23a) (Type,	Print)						-	
		KALU	UMP	1 2	10 BU	SINE	SS CEN	TER DR	371	REI	STER	5502	~~	MD	2113.6
Sta	_	31. Date filed (Mon	NOV $1$	2 2007	32. Filigis	trar's Signa	ature	met.							
Registr	al		MUA T	9 4001	1468	BONG S	35	3, 3, 4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland Department of Health and Mental Hygien 2007

1- State Amend 4a, perMD, g873, 11/13/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month **Physician** 7=15AM Martha Shelley 28 2007 OCT /Medical 4a. Facility Name (If not institution, give street and number)
Fisher's House
2901 E. Strathmore Ave. 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 ☐ M 2 🕏 F 219-26-7559 Yrs. Director 79 Pa. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County three rivest by notified at Yes 2□No Director Md. <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 E. Strathmore Ave. 21214 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: Black other traumatic avent, I'm Mudical Exter-3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) Disabled 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o HELEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21216

21216 Edward Spicer ျှ 19a. Informant's Name/Relationship (Type, Print) it of Health 2555 W. Lafayette Ave., Baltimore, Md. SHARON Williams Washington Niece Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Mt. Zion Cem. 11-2-07 Lansdowne, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East Branfomullan 21202 1101 E. North Ave., Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) sefsis Physician 2 weeks /Medical Due to (or as a consequence of): Examiner 15chema -Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Per-pheral Voscular Discosa that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hypertension Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assiste Other: 4 Nursing Home 5 Residence 6 X ther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after deat Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 9,2007 45757 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) Matthew K McNibney 4940 Eastern BOH, MD 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Registrar

2007

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

4 Homicide

3 Suicide

29a. Certifier

1 Natural

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** Director

permit Pages 1 end 2 should be filed within 72 hours after deeth with the Marylar Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "netural", or iteme 23a or 28a-1 show any injury or other treumatic event, Ita Madical Examinat must be notified at one.

For State (	of Maryland / D	epartment of H	lealth and	Mental Hygi	ene	
State Registrar		Certificate of	Death	Re	g. No. 200	7 3625
Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
Alexander Starr				November	,	10 00 10
. Facility Name (If not institution, give street and no	ımber)	4b. City, Town, o	r Location of Dea		4c. County of De	ath
INAI HOSPITAL OF BALT	TIMOR€	BALTIM	ORE CIT	14	N/	'A
Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs Hours Min		Year) 9. B	irthplace (State or Foreig Country)
218-14-1124 IAM ZUT	84 Y	rs.		March 3,	1923 Ma	ryland
Da. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
N/A	R	altimore				1 X Yes 2 No
aryland N/A	De	10f. Zip Code		10	g. Citizen of What (	Country?
3021 Fallstaff Road			1209		USA	•
	cedent Ever in U.S.			Specify Yes or No-	14. Race - An	
Amade	orces? 2□No 1943 ive 1945	13. Was Decedent of H	an, Mexican, Puer	to Rican, etc.)	Black, Wh	
3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or I	ive 1945	1 ☐ Yes 2 🗓 No	Specity:		Specify: W	hite
15. Decedent's Education	16a. [	Decedent's Usuat Occup	ation	. 1	6b. Kind of Busines	s/Industry
(Specify only highest grade completed Elementary/Secondary (0-12) College	1-4or 5+)	Give kind of work done life. DO NOT use retired	during most of wo d)	nking		
3	]	Redactor			Printi	ng
Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	laiden Sumame)	
Samuel Starr			Ida	Weitzman		
a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street	and Number or R	ural Route Number,	City or Town, State,	Zip Code)
Beatrice Starr, Wife	30	21 Fallstaf	f Road B	altimore,	Maryland	21209
a. Method of Disposition	cometee	Disposition (Name of , crematory or other place	ce)	Date 2	Oc. Location - City of	r Town, State
1 ☐ Burial 2 XX Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		Crematory I	$n_{\rm C}$ $11/$	13/07 E	altimore,	Maryland
Signature of Funeral Section Licensee		22 Name and Addre				
Thomas Gregor		Cremation 299 Frede	rick Roa	d Baltimo	re, Maryl	and 21228
<ol> <li>Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on</li> </ol>	caused the death. Do no	t enter the mode of dyir	ig, such as cardia	c or respiratory arre	st,	Approximate tnterval Between
nmediate Cause (Final sease or condition	CO OT D	225				Onset and Death
sulting in death)	(or as a consequence of	EED 1:				9 days
CP	· ·	STRITIS				8 months
equentially list conditions, b. Due to use. Enter Underlying	(or as a consequence of					o nains
use (Disease or injury tt initiated events						
ulting in doath) I get	(or as a consequence of	):				
d						
D. Was decoder pregnant	tcome of pregnancy birth 2  Fetal death	2□Estania			23d. Date of d	etivery
in the past 12 months?	nant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	Month	Day Year		
9 Unknown 9 Unkr	own					

/Medical Examiner the attending physicien and hed for use as the burial-transit Physician/Medical

Examine

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Medical Certification; To

**Physician** 

detached been signed by the should be detach Be Completed

To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funerel Director: After this certificate has t completely filled in by the funeral director, page 2 s

4+1

State Registrar 29b. Signature and title of certifier RESIDENT Kendelner

HYPOTENSION

5 ☐ Pending investigation

6 Coutd not be determined

29c. License number RES-000

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) NOVEMBER, 10, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed? 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL OF BALTIMORE MBBS SINAI SRIRATNA: KONERU

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32 Anglistrar's Signature

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fb 9881 7-31-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U U 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** W. Ibert Strikland 9:10 AM 2007 00 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Daltonine Parkuille Gracis Cromwell Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 XM -0 Yrs. Director Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at 1 **Y**es 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? . Street and Number 6 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced ear or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) lesman 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be arrionette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Balto. MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 R 3 □Removal from State 21. Signature of Funeral Service Lice Name and Address of Eacility u buckd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute rend failure **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Concu Prostate with metastocces 7-20.65 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown ambreyla Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an YEYNESIGN autopsy performed? 2 No 25. Was case referred to medical examiner? 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: Director: After this certific Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Tyes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1-Natural death. м 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kles D31295 11/2/02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21264 SI Suite 4202 6701 N Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Ser Server

		For	State of Ma	aryland					and M	ental H	ygien	е	0 =		
		State Registrar			Ce	rtificat	e of L	Death			Reg. N	.20	U/	3626	
Physici	an	1. Decedent's Name (First, Middle, SILVIA	SCH C	CHE	T					2. Date of D Month	D	ay	Year	3. Time of Death	
/Medic		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or	Location o		NOVEN		c. County		0 , 00 11	
		NORTHWEST HOSE	ITAL CENTER					LSTOW	IN			BALT	IMORE		
Funeral		5. Social Security Number <b>212-09-6981</b>	6. Sex 7. Ag 1 ☐ M 2 <b>X</b> F	e ( <i>In yrs. la</i>	st birthday) Yrs.	If Under Months	1 Year Days	If Under I	Min.	8. Date of B (Month, E	ay, Year		9. Birthpl Coun		ign
Director		Usual Residence of Decedent								01/06/	191	<u> </u>		MD	
ıryland s <b>how</b>	_	10a. State 10b. County	MODE	1	Town or Lo								11	Od. Inside City Lim	
he Ma 28a-f s otiffier	Director	MD BALTI	MUKE	OMIN	IGS MI						10.0			1 □ Yes 2 <b>X</b> 1	10
ath with t 23a or 2 ust be n		4730 ATRIUM CO	URT #250			10f. Zip	211	17			10g. C	itizen of W <b>U</b>	.S.A.		
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give X Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes	cify Cuba	spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto F	cify Yes or N Rican, etc.)	ło-		, White,	an Indian, etc. WHITE	
5-00	ted	15. Decedent'. (Specify only highest				dent's Usua kind of wor			t of workir	na	16b. I	Kind of Bus	siness/Inc	lustry	
Maryland 21215-0036 at 2 should be filed within 72 hours af th and Mental Hygiene. Its marked other than "natural", or traumatic event, the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	MAKER	se retired	)	t or workin	'g		OWN	HOME	<u>.</u>	
laryland 2 2 should be filed and Mental Hygi is marked other aumatic event, t	Be	17. Father's Name (First, Middle, L	ast)		SH0S	TACV			er's Name INIE	(First, Middl	e, Maide		₉₎ WARZ		
aryla should and Men s marke umatic	٦ ک	19a. Informant's Name/Relationsh	ip (Type. Print)	-			(Street a			I Route Num	ber. Citv			Code)	
and 2 seath ar n 27 is ser trau		HARVEY SCHOCHE								INDA.	, ,		, ,	2000)	
altimore, rmit. Pages 1 ar partment of Hea portant: If item y Injury or othe		20a. Method of Disposition 1   M Burial 2 □ Cremation		20b. Pla	ace of Dispo	sition (Nan	ne of ther place	e)	D	ate	20c. l	_ocation - (	City or To		
timor t. Pages tment of l tant: If ite		4 Donation 5 Other (Sp	ecify)	WORK		CIRCL				/2007		ALTIM			
Baltimol permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service L	Ruger				REIS	TERST	OWN	L LEVI ROAD -	· PIk			NC. MD 212 <mark>0</mark> 8	
		23a. Part1. Enter the disease, or o shock, or heart failure. List o	or plic dons that caused inly or excluse on each li	d the death. ne.	Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. A CUT Due to (or as			AUD	MIL	- 11	1 = 6	ARCT	100	)	_		
Examiner			b.	a conseque	erice oil).										
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xecute end Il-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):										
B760, Cate be executed by sician end the burial-transit	dical E			,											
68 rtificat g phy as the	Medic	JE EENAM E												*	
I Records, P.O. Box 6. The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome 1 ☐ Live birth	2 Fetal	death 3	∃Ectopic pr						23d. Date		ry Day Year	
P.O.	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	ath 5L	Other (sp	ecify)								
15, P.O.		Part II. Other significant condition	1 -	ut not resul	ting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contri	bute to th	e cause of death?	
Vital Records, sician: The law requires the certificate has been signerector, page 2 should be d	Completed by	HALERIENS	100							1	]Yes :	2□ No	3 ☐ Prob	ably 4 Unkno	νn
e 2 sh	nple									24a. Wa aut	opsy	24b. V	Vere autor	osy findings availal	ole of
Vital Rec		05 Wee construction	1							1□ Yes	-/-	lo 1	eath? □Yes 	2 No	
ysicia ysicia is certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Appatie	ent 2∏E	R/Outpatier	nt 3 🗍 DO	A Othe	٠		<i>(Check only</i> ne 5□Res		6 □Othe	er (Specifi	/)	
On Or ding Phys	Ë	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f 2	8c. Injury Work			28d. Describe			(-//	,	
VISIO  r Attendii er death. rector: A by the fu	catic	2 Accident investiga 3 Suicide 6 Could no	ation	0.0		М	1 🗆 \	∕es 2∐I		or I	<i>(</i> 2).	T			
DIVISION OF all or Attending Physical death. In Director: Atter this of in by the funeral di	Certification:	4 ☐ Homicide determin	28e. Place of injusted building, et	c. (Specify)	ne, iami, str	eet, ractory	, onice		2	City or To	(Street a own, Sta	te)	er or Hura	l Route Number,	
DIVISION Or VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical (	29a. Certifier (Check only one)  Certifying 2 Medical E	Physician: To the best examiner: On the basis o and manner sta	f examinati	ledge, deat on and/or in	h occurred avestigation,	at the tim	ne, date an pinion, dea	nd place, a	and due to the ed at the time	e cause( e, date a	s) and mai nd place, a	nner as st and due to	ated. the cause(s)	
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12		30. Name and address of person w		AIRI		Print) 5	401	OL MINI	D (	12011	TR	DAG JE	. W	D 21133	
Sta	te	31. Date filed (Month, Day, Year)	36 Benistr	ar's Signati	ire fra	م فو	ONCI		( ) (	10.11		*			
Registr	_	NOV 1 3 2	2007 January	, D.	Popul	MI.									
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State of Maryland / Department of Health and Mental Hygien 2007

			1 - For State Registrar	Amend #5,p	State o erInf 0874,	f Marylan 12/19/07	d / Depa 'TT <i>Ce</i>	artmen rtificate	t of H e of L	lealth a	and Menta		enæ () g. No.	07	362	262
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	Exa	miner			, give street and nur	mber)				Location of				y of Death		
			BROADME							VILLE			BA	LTIMO		
	Funer		5. Social Security	Number	6. Sex 1 ☐ M 21 ☑ F	7. Age (In yrs. 93	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min. DA	o of Birth	Ye <i>ar</i> )	9. Birthi	olace (State ntry) MD	or Foreign
	Direct	or	Usual Residence	9802	Λ	93	113.				04/2	.0/19	14		טויו	
	land ow		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside C	City Limits
	Mary Hish	ğ	MD	BALTIN	10RE		COCKEY	SVILL	Ε						1 🗌 Yes	2 No
	the	Funeral Director	10e. Street and N	lumber				10f. Zip				10	g. Citizen of	What Cou	ntry?	
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	36 after dea or Itams	正	1 Never Ma	rried 2 Marri	ed 1 ☐ Yes If Yes, Giv	2 👿 No					n, Puerto Hican,	Btc.)		ck, White,		
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X	The la	E E										autopsy perform	ed	prior to co death?	mpletion of	cause of
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	ttendir death. ctor: At	atic	2 Accident	investig	ation		,,	М		Yes 2	No					
	> 4 = 8 0	Certification:	3 Suicide 4 Homicide	6 ☐ Could n determi	ned 288. Place	of Injury - At ho ng, etc. (Specify	ome, farm, str	eet, factory	, office			ation (Strey or Town,	et and Num State)	ber or Rur	al Route Nur	nber,
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	¥	$\downarrow$	30. Name and ad	dress of person v	who completed caus	e of death (It m	23a) (Type,	Print)		1				,	2	1030
		_	BARBA	KH C/	IKKOLL	MIL	)-, /	3801		ORK	CRD.	, COC	CKE)	15 VI.	UE,	MD
		State istrar	31. Date filed (Mo	NOV 1	3 2007	agistrar's Signa	S A	ports.	,9				,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 State of Maryland / Department of Health and Mental Hygiene Per FH G873 11/16/07 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 8, 200 **Physician** /Medical MATTIE SLAUGHTER 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b_City, Town, or Location of Death and GHERRA Baltmare N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5.290 61 Secrity Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Hours 40 61 **Director** DEC.4,1945 MD. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 319 S.DALLAS COURT 21231 USA by Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other th any Injury or other traumatic event, the once. 12th security Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fuller Branch ALVA MILLARD ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENEEN SLAUGHTER (daughter) 1517 N. STRICKER ST. BALTO, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 16,2007 NOV. 1 ☐ Burial 2 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GREENMOUNT CREMATORY BALTIMORE, MD. ature of Funeral Service Licenses 22. Name and Address of Facili SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** arrythmia /Medical Due to ( as a consequence of): Examiner diseme Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusto for as a consequence of) i records, P.O. Box 68760, 7. The law requires that the death certificate be executed HTN burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 ☐ Inpatient 2 DER/Outpatient Certification: To 3□ DOA this 27. Man r of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral After t 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. Meratel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Wonth, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2007

State of Maryland / Department of Health and Mental Hygiene 2007 36264 Grace Giomento Sommerhof Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Grace Giunento Sommerhof Physician/ November 10, 2007 2205 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore County Towson 622 Coventry Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Social Security Number 6 Sex **Funeral** Hours Min Months Davs Country) 11/14/1928 78 Director 200-22-3459 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Yes 2 X No items 23a or 28a-f shov . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. rtant; If item 27 is marked other than "natural", or items 23a or 28a-f show or other transmatic event, the Medical Examiner must be notified at once. MD Baltimore Towson Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21204 USA 622 Coventry Road 14. Race - American Indian, Black. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 x No White Yes, Give Year Yes 2 X No specify: Divorced 3 XWidowed ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) MD 21215-0036 Teacher Nursing Program 4 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michele Sberne Cataldo Glumento, II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Towson, MD 21204 Roy Andrew Sommerhof, III 415 Chestnut Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley 11/15/2007 Timonium, MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 York Rd Funeral Home Rd. elle Ruck Towson Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death M-dical a Atherosclerotic cardiovascular disease complicated by hypothennia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical #1,23a,27,28a-f. X UNPENDED X signed by the attending physician I be detached for use as the burial perME.g873.11/21/07 TT Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 ✔ Unknown 41- Middle Name Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy death? performed? Yes 2 V No 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 After this 1 V Yes ို 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 1 Natural 1 Yes 2 X No subject exposed to cold Pending death. Fnd 11/10/2007 Fnd 9:10 pm Director: Investigation 2 X Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc by within 24 hours after To the Funeral Dire 3 Could not be or Town, State) Suicide 622 Coventry Rd. Towson, MD (Specify) Found: residence (in basevent) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 11, 2007 O.C.M.E. my 30. Name and address of erson who completed cause of death (Item 23a) Me pero 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 32. Reistrar's Signature 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

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		-	For State Registrar	State of Marylan		iment of r <i>ficate of</i>		vientai riy	glene Reg. No. 201	07 36265
	Physicia	an	1. Decedent's Name (First, Middle, La	Nicole Thom	as			2. Date of De	eath Day Y	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	re street and number)		lb. City, Town, o	or Location of Death	Novem	4c. County of	007 432 TM
	Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	SCOUL If Under 24 Hrs. Hours Min.	8. Date of Bir	th year) 9	Birthplace (State or Foreign
-	Director		219-71-9475 Usual Residence of Decedent	1□M 2 <b>∏</b> F	2 Yrs.	violitis days	Hours Will.	March 28		Maryland
	aryland show	_	10a. State 10b. County MD Balt:	imore 10c. City	y, Town or Loca Rosed					10d. Inside City Limits 1 ☐ Yes 2 📉 No
	n the M r 28a-f r notifie	Director	10e. Street and Number	Z.MOT C	ROBCG	10f. Zip Code			10g. Citizen of Wha	at Country?
	sath wit s 23a o nust be	eral D	1206 Philco	Road  12. Was Decedent Ever in U.	C 12 W	21237		pocify Voc or No	United St	ates American Indian,
036	should be filed within 72 hours after death with the Maryland Ind Mental Hyglene. s marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1 [	]Yes 2 <mark>⊠</mark> No	, ,		Black, Specify:	White, etc. White
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212	ed with ygiene. ner thar it, the N	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ever w	orked		None	<u> </u>
land	2 should be filed and Mental Hygi is marked other aumatic event, t	To Be	17. Father's Name ( <i>First, Middle, Last</i> Phillip Thom	,				er Schwen	, Maiden Surname) Mer	
Maryland 21215-0036	Ø @ ₹ @		19a. Informant's Name/Relationship (Phillip Thoma						er, City or Town, Sta	
Baltimore,	(i) Q I		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci	20b. P	l Place of Disposit Dreland Park		•	Date / 12 / 07	20c. Location - Cit	
Balti	permit. Page Department Important; II any injury o		21. Signiture of Funeral Service Lice	Evals	Eva 3	иемроз	C DIIVE	r orest	Cremation S Hill, MD	Services 21050
			23a. Part . Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that caused the death one cause on each line.	h. Do not enter	the mode of dyi	ing, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Fatal Due to (or as a consequence)	uence of):	nmi		1		
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or a a consequence	uençe of):	0+ 6	reat	Vessi	els	_
V	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Golden Due to (or as a consequence)	Har	_54r	ndrom	10		
68760,	tificate be executed g physician and as the burial-transit	edical E	•							
	e death certific he attending p led for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 □E	ctopic pregnanc Other (specify)	су		23d. Date of Month	,
, P.(	uires that the de signed by the a ld be detached f	y Phy	Part II. Other significant conditions	contributing to death but not res	ulting in the und	erlying cause gi	ven in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
ords	requires een sign oould be					-		10	Yes 2 No 3	Probably 4 Unknown
I Rec	rsician: The law require s certificate has been sig lirector, page 2 should b	Completed						24a. Was auto perf 1∐ Yes	ormed2   dea	re autopsy findings available or to completion of cause of ath? IYes 2 ☐ No
Vita	sician: s certific lirector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Ot	26. Place of Dea		one) idence 6 □Other	(Spacify)
n or	Ing Phy Ifter this Ineral d	on: To	27. Manner of Death  1 Manual 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	iry at ork?		how injury occurred	
Division or Vital Records, P.O. Box	I or Attendi after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	De Bloco of injuny At he	ome, farm, stree fy)		Yes 2 No	28f. Location ( City or To	(Street and Number wn, State)	or Rural Route Number,
u	Hospita 24 hours Funeral etely filled	Medical Ce		hysician: To the best of my kno miner: On the basis of examina and manner stated.						
	To the within To the	Me	29b. Signature and title of certifier	0500			se number 54428		29d. Date signed (	Month, Day, Year)
	2		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, P				11-10	1 200 1
	Sta	to	Dr. Michael Pig. 31. Date filed (Month, Day, Year)	OKIN 9000 F	ranklir atyre	1 <u>59ua</u>	re Dan	re Ba	Homore	m/ 21237
	Registr		NOV 1 3 2	2007 La serie de	C. GOM	age of				

DHMH 17 Rev 1/2001

State
Registrar

2007 August St factor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POLA

RATA KUMAR

31. Date filed (Month, Day, Year)

900 CATON AVENUE Baltimore MD.

			Please	State of Maryla					•	le.
		-	For State Registrar	——————————————————————————————————————		rtificate of			g. No. 2	7 36267
Phys /Me	sicia edica	al .	1. Decedent's Name (First, Middle, L	LEWIS		UNTERMA		2. Date of Death Month NOVEMBER	^{Day} 200	
Exa	mine	er	4a. Facility Name (If not institution, gi 7 COLUMBINE COL			4b. City, Town, o	or Location of Death	1	4c. County of BALT.	I MORE
Fune Direct			132-38-2507	Sex 7. Age (In yrs 61	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, 1940) 07/02/194	(ear) 16	9. Birthplace (State or Foreign Country)
e Maryland a-f show tifled at		_	Usual Residence of Decedent  10a. State 10b. County  MD BALTII		City, Town or La	CIMORE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with that a or 28		Dire	10e. Street and Number 7 COLUMBINE CO	HRT		10f. Zip Code 2120	9	10	g. Citizen of Wh	at Country?
Ind 21215-0036  be filed within 72 hours after death with the Maryland ttal Hygiene. the Hygiene "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		by Fur	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?			Hispanic Origin? (Sean, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race	- American Indian, White, etc. WHITE
21215-0036 d within 72 hours aff giene. er than "natural", or the Medical Exami		Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education trade completed)  College (1-4or 5+)	16a. Dece (Give life. MANAG		pation during most of wor d)	king 1	6b. Kind of Busi	
ed al be		a B	17. Father's Name (First, Middle, Las	st)	UNTER	NA 0 B 2		ne (First, Middle, Ma	aiden Surname,	
Maryland 2  2 should be filed to and Mental Hygin  7 Is marked other traumatic event, the		ှင်	IRVING  19a. Informant's Name/Relationship	(Type. Print)	UNTER 19b. Mailii		JANICE and Number or Ru	ıral Route Number,	City or Town, S	NELSON tate, Zip Code)
Z 5 # 5 # 5		- 0	DONNA UNTERMAN	·		DLUMINE C	OURT - BA	LTIMORE.		
Page Page nent o			20a. Method of Disposition  1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Special Contents)	□Removal from State BAI	LTIMORE	mater of cineripla HEBREW	^{ce)} 11/11		REISTERS	ity or Town, State TOWN, MD
Balt permit. Departr Imports any initia	ouce.		21. Signature of Funeral Service Lice	ensee	22	2. Name and Address 8900 REI				ROS., INC. LLE. MD 21208
Physicia /Medic	cal		23a. Part & fitter the disease, of co sho k, or h art failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the de- ly one cause or each line.  a	cell		ng, such as cardiad		st,	Approximate Interval Between Onset and Death
be executed sician and burlal-transit		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as a conse						
VISION OF VITAL RECORDS, P.O. BOX 687 Attending Physician: The law requires that the death certificate closeth. Coeath. Output: After this certificate has been signed by the attending physical properties of the funeral director, page 2 should be detached for use as the		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Mont	of delivery th Day Year
Cords, P. w requires that a been signed by should be deta		2	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	10	oute to the cause of death?  B Probably 4 Unknown
or Vital Records,  Physician: The law requires the trinis certificate has been signer rail director, page 2 should be d		Completed						24a. Was an autopsy perform	ed? de	ere autopsy findings available lor to completion of cause of eath? □Yes 2□No
· Vital  /siclan: 1 s certificat		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ott	ner:	ath <i>(Check only one</i> lome 5 DResider		(Specify)
On Or Iding Phy Ith.: After this			27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju Wo		28d. Vescribe hov		
Division or  I or Attending Phys after death.  Director: After this d in by the funeral dir		Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm, str cify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Numbe State)	r or Rural Route Number,
Division  To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		Medical C	29a. Certifier (Check only one)  1 Certifying F	Physician: To the best of my k aminer: On the basis of exami and manner stated.	nowledge, deat nation and/or ir	th occurred at the ti	ime, date and place opinion, death occ	I e, and due to the ca urred at the time, da	use(s) and man ite and place, a	ner as stated. nd due to the cause(s)
To the within 2 To the complet		Me	29b. Signature and title of contifier	) / 110		29c. Licens	se number	29	d. Date signed	(Month, Day, Year)
1	Q	-	30. Name and address of person wh	o completed cause of death (It	em 23a) (Type,	Print) HOSPIT	717 1411	1 W RFO	VEAF	NE TVE BA
80	Stat jistra		31. Date filed (Month, Day, Year)	.007 A Registrar's Sig	mature (	wh	,, = 0,0	, , , , , ,	70	10, 2007 NE TVE, M.

			For State Registrar	State of I	Maryland		artmen rtificate			nd M			007	36268
	Physicia	an	Decedent's Name (First, Middle     Maxine	, Last)			landi		-		2. Date of Dea Month	th Day	Year 2007	3. Time of Death 5:20 P M
eline.	/Medic Examin		4a. Facility Name (If not institution, Union Memoria	give street and numberal Hospital	er) L		4b. City,	Town, or	Location of	-	Novembe		unty of Death	
*,	Funeral Director		5. Social Security Number 219–26–8550	6. Sex 7. 1 □ M 2 □ F	Age (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day 3-20-1	, Year)		place (State or Foreign ntry) Md •
٦	p		Usual Residence of Decedent  10a. State 10b. County			, Town or Lo	cation				J 20 1			10d. Inside City Limits
	e Mary 3a-f sho tiffed a	Director	Md.	NA		Bal	timor	е						1 X Yes 2 □ No
	with th	I Dire	10e. Street and Number 2782 The Alai	meda			10f. Zip	Code <b>212</b>	18			10g. Citizer	of What Cou USA	ntry?
000	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  To fleatin and Mental Hygiene.  or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Novorced	12. Was Decede Armed Force	s? <b>{</b> No		Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	jin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	Sp	,.	lack
1213	within 72 h ene. than "natu ne Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	or 5+)		dent's Usua kind of wol DO NOT us i Cle	rk done d se retired	ation luring most )	of workin	g		of Business/li	er Market
2	e filed al Hygi I other vent, tl	Be Co	10th grade 17. Father's Name (First, Middle, i		l						(First, Middle,	Maiden Su	rname)	
) Ja	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the M	은	Berzilaus  19a. Informant's Name/Relationsh	Leonard	d E	Peters		(Street a		llie	I Route Numbe	lazel er. City or Te		hultz
≥ ບົ	. Pages 1 and 2 s ment of Health an tant: If item 27 is jury or other trau		Bryan Vanland 20a. Method of Disposition	ingham			09 Pi	scha	ta Wa	y La		r., c		, Md. 20735
	Li Ti de Pa		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)	ite i .	ing Me	m. Pk	•		11-1				wn, Md.
0	permit. Departr Importa any Inju	G V	21. Signature of Funeral Service	A					ss of Facility North		March E ., Balt			21202
	Physician /Medical Examiner	5.	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	sed the death h line. as a consequ	Info	rction			cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death 2 weeks
	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ									
O. DOX 0	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 127No 9 □ Unknown		n 2□Fetal t at time of de	death 3	]Ectopic pr ] Other (sp					230	d. Date of deli Month	very Day Year
COINS, T	uires that signed b Id be deta	þ	Part II. Other significant condition	ons contributing to deat	h but not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to			the cause of death?
	n: The law req icate has beer r, page 2 shou	Completed									1□ Yes	rmed? 2 ☑ No	prior to c death?	topsy findings available ompletion of cause of 2 ☐ No
<b>1</b>	ystciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inp	atient 2	ER/Outpatier	nt 3 DC	Othe	D.F.:		<i>(Check only o</i> ne 5 ☐ Resid		☐Other (Spec	eify)
VISIOII O	nding Ph tth. r: After th e funeral		27. Mannet of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	4	Injury <i>Day Year)</i>	28b. Time o Injury	f 2	28c. Injun Worl 1 □	yat k? Yes 2 □ N		8d. Describe h	now injury o	occurred	
	To the Hospital or Attending Physician: The law within 24 hours after deadh.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could r 4 Homicide determ	and Zoe. Place of	injury - At ho , etc. <i>(Specif</i> )	me, farm, sti	reet, factory	y, office		2	8f. Location (8 City or Tox	Street and f vn, State)	Number or Ru	ral Route Number,
	Hospi 24 hour Funera etely fills	edical (		g Physician: To the be Examiner: On the bas and manner	s of examina									
	To the within To the comple	Mec	29b. Signature and title of certifier						e number				signed (Month	
	.n		30. Name and address of person	ene Do	of death /Itam	23a) /Tuna	Print\	H00	61180	)	ire, me	Novem	her 5	,2007
	12		Elliot Share D.	0. 201 Fa	4 Um	versity	Jorn	way	Ba	/time	ire, ma	rylan	2 21	2/8
	Sta Registr		31. Date filed (Month, Day, Year)	3 2007 32.009	istrar's Signa	ture,	andi	P			,	•		

DHMH 17 Rev 1/2001

36269

		•	For State Registrar	Otate of IME	arylaria /	•	rtificate of l			g. No.	00203
4	Physici	an	1. Decedent's Name (First, Middle,					7	Date of Death     Month	Day Year	3. Time of Death
3.7	/Medic	C 400 10	William Kei  4a. Facility Name (If not institution,		ZO		4b. City, Town, or	Location of Death	November	9 2007 4c. County of Dea	6:53 p M
	Examir	er	303 Loblolly W				Grason			Queen A	nne
94.	Funeral Director		J44-J4-20J4	. Sex 7. Ago 1 M 2 □ F	e (In yrs. last <b>48</b>	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUL 31	9. Bir 1959 II	thplace (State or Foreign cuntry) Linois
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits
	e Mary a-f sh lified	ctor	MD Queen	Anne	Gra	sonv	ille				1 □Yes 2X No
	vith the	Dire	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	ountry?
	eath v ns 23a must	Funeral Director	303 Loblo11y W	12. Was Decedent I	Ever in U.S.	13. \	21638 Was Decedent of H		pecify Yes or No-	USA 14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puert Specify:	o Rićan, etc.)	Black, Whi	nite
5-0	72 ho 'natur dical	eted	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	6b. Kind of Business	/Industry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		er Carpen			Construct	ion
d 2	filed Hygid other ent, th	Be Co	17. Father's Name (First, Middle, L.	ast)			<u>F</u>		ne (First, Middle, M		
Maryland	uld be Mental rked (	To B	Richard Vinc	enzo, Sr.				Agnes	Piper		
lary	2 sho and h is ma		19a. Informant's Name/Relationshi		1	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
	1 and Health am 27 ther tr		Deborah Vincen  20a. Method of Disposition	zo - wife			Loblolly sition (Name of	Way, Gra		MD 2163	
Baltimore,	ages ant of h t: If ltc		1 ☐ Burial 2 ☐ Cremation		cem	etery, crei	matory or other plac	i i .			,
Ħ	nit. P partme ortani Injun		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L							Baltimore and, Inc.	, MD
ä	Depari Impor any Ir		Ste Ste	ven H. Will	lams	0	299 Frede	rick Roa	or maryı d. Baltin	and, Inc.	21228
			23a. Part1. Enter the disease, or coshock, or heart failure. List o	omplications that caused nly one cause on each li	the death. [ne.	Do not ent					Approximate Interval Between Onset and Death
	Physician	ΪÌ	Immediate Cause (Final disease or condition resulting in death)	_aA	este	Marc	elad (	euker	né		Onset and Dead
ng.	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):					i
	10	Je .	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequen	ce of):					
da	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
30,	e exe cian al unial-t	EX	resulting in death) Last	Due to (or as	a consequen	ce of):					
,09289	rificate be executed g physician and as the burial-transit	Medical		d							
Box 6	E 50 0	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of de	elivery
m	that the death cer ed by the attendir detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 4□Pregnant a 9□Unknown			∐Ectopic pregnanc ☐ Other (specify) _	y		Month	Day Year
P.0.	at the I by th stache	Phys	9 ☐ Unknown				1.1.	and Death	OO a Did tob	agge use contribute	to the course of death?
	es gu	þ	Part II. Other significant condition	s contributing to death b	ut not resultin	ig in the u	nderlying cause giv	en in Part I.		s 2 No 3 F	to the cause of death?  Probably 4 Unknown
Records,	w requir been si should	Completed				*****			24a. Was ar		autopsy findings available
Rec	e r e	ldmo							autops perform	v prior to	completion of cause of
ital	sician: Th certificate rector, paç	Be Co	25. Was case referred to medical	4				26. Place of Dea	1 Yes 2 ath (Check only one	-	s 2 No
<u>v</u> <	S S	10 E	examiner? 1 🗆 Yes 2 📉 No		ent 2□ER			T I Italianing i		nce 6 □Other (Sp	ecify)
o uc	ding Phy h. After thi funeral	iuo	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Bb. Time o Injury	Wor		28d. Describe ho	w injury occurred	
Division or Vital	Attending r death. ector: After by the fune	icat	2 Accident investiga 3 Suicide 6 Could no	t be 28e. Place of inj	ury - At home	e, farm, sti	reet, factory, office	Yes 2 □ No	28f. Location (St	reet and Number or I	Rural Route Number,
<u>≥</u>	al or A after I Dire	Certification:	4 ☐ Homicide determin	building, et	c. (Specify)				City or Town	, State)	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical C		Physician: To the best xaminer: On the basis of and manner st	f examination						
	To the within 2 To the comple	M	29b. Signature and title of certifier				29c. Licens		2	9d. Date signed (Mor	nth, Day, Year)
							D H	1486		41010	1
	Ŋ		30. Name and address of person v	Starff, 1	31 AV	330	E Merom	ent St S	wile 730	0 Battin	uch Hill gross
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 3		ar's Signatur	So	sile				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month Decedent's Name (First, Middle, Last) Day 200^{Year} Physician Christine VANIK Armeta 8:18AM 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson St. Joseph Medical Center 8. Date of Birth (Month, Day, Year) Feb. 21, 1937 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 XF Yrs. Director 70 216/34/5118 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🛠 🔀 No **Funeral Director** Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 USA 7812 Overhill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveXX Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white þ 3 ☐ Widowed ★☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hiant: If item 27 is marked oth Be Lala (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Regester Ave. Baltimore, MD 21239 Ms. Vicky Vanik (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 XX Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Glen Haven Mem. Park 11/10/07 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Singleton Funeral Home, 1 2nd Ave SW Burnie mode of dving. 23a. Part LEhter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Complications **Physician** /Medical ue to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼ No 24a. Was an perform certificate within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) auto acci 1 ☐ Yes 2 ☑ No den 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Pighuay 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Fighuay 28f. Location (Street and Number or Rural Route Number) SSRY Mary Land 21221 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28f. Location (Street and Number or Rural Route Number) SSRY Mary Land 21221 3 Suicide 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

ella

2007

6 Trimble Hill

29c. License number

CT. Lytherville, Md 21093

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** November 2000 /Medical Facility Name (If not institution 4c. County of Deat! or Location of Death give street and number) City, Town Examiner 1 ge (In yrs. last birthday, If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 218-22-5825 Months 1□M 221 Days Hours Marchas yland Director mar Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 res 2 No N Mal, Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Newer Married 2 Married Saltimore, Maryland 21215-0036 2 No a Specify: Completed by 3 ☑ Vidowed 4 ☐ Divorced 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) oduction -15 (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last). Mother's Name Be Car 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flowerton - daughter wende 223 20a. Method of Disposition

1 Burial 2 Cremation 200 Location - City or Town, State 20b. Place of Disposition (Name of Date 3 Removal from State bodlawn Cemeter 4 Denation 5 Other (Specify) 22. Name and Address of Faul 21. Sign ure of Funeral Service Ucensee ·md . 21229 23a. Part. Entor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Sew Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) **Physician** ACUTE VENTRICULAR ARRHYTHMIA hour /Medical Due to (or as a consequence of): Examiner D. ACUTE MYOCARDIAL INFARCTION Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit CARDIOVASCULAR DISEASE ATHEROSCIERUTIC and Due to (or as a consequence of): .O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 HInknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 → NO 3 Probably 4 Unknown 1 ☐ Yes END STAGE RENAL PAILURE PERIPHERAL YASCULAR Completed DISCASE 24a. Was an 24b. Were autopsy findings available HYPERTENSION prior to completion of death? 1 ☐ Yes 2 ☐ No autopsy performed' certificate 2 100 DIABETES MELLITUS 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 3 DOA မ 2 ☐ ER/Outpatient this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

10

30. Nany and address of person who completed cause of death (Item 23a) (Type, Print)

200

I. Snyder

Jerome 31. Date filed (Month, Day, Year) 32 Registrar's Signature

8002648

900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

November 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Sulvia **Physician** Warner 138 PM 10 2007 November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death Examiner byshwest Randallstown Baltimone 6 Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M **X**□XF 220-16-1047 87 Apr. 27, 1920 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes XX No Director Maryland Baltimore Owings Mills 10g. Citizen of What Country? United States of America 10e. Street and Number 10f. Zip Code 6 Cedarmere Road 21117 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No White Specify: Specify: þ 3 ☐ Widowed XXDivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Laundry Worker Rosewood Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Tillman Jetta Vaughan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Cedarmere Road, Owings Mills, Maryland 21117 Harold W. Warner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. Date 3, XX Burial 2 ☐ Cremation 3 □Removal from State 2007 Wards Chapel Cemetery Randallstown, MD 4 Donation 5 Done (Specify) 21. Signature of Funeral Septific Licen-Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rear failure. List only one cause on each line. Immedia e Cause (Final disease or condition resulting in death) Physician 2 days ocardial /Medical Due to (or as consequence of): 10 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has irector, page 2 autopsy performed? Yes 2 No Failure Kidney 1∐ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined 29a. Certifier 15Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifier

Jessa Ede

31. Date filed (Mon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

eman MD

Registrar DHMH 17 Rev 1/2001 29c. License number

D006617

Old Court Road Randallstown MP

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

	Please Type or Print in Black Indelible I State of Maryland / Department of	
	1 - State Registrar Certificate	of Death Reg. No. 2 0 0 7 3 5 2 7
hysician /Medical	Decedent's Name (First, Middle, Last)     SUSAN PATRICIA WOLFE	November 11, 2007 12:00 A.
xaminer	Stella Maris Hospice Timo	wn, or Location of Death  Ac. County of Death  nium  Baltimore
neral ector	5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Rountry)  May 6, 1942  9. Birthplace (State or Foreign Country)  Georgia
-f show fled at tor	10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Towson	10d. Inside City Limit 1 ☐ Yes 2 🏋 N
3a or 28a-f si st be notified al Director	10e. Street and Number  1600 Dennis Avenue	ode 10g. Citizen of What Country?  U.S.A.
Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		t of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
t, the Medical Ex Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Occupation done during most of working letired) 16b. Kind of Business/Industry
d other the event, the Be Con	5+ years School 1  17. Father's Name (First, Middle, Last)	Teacher Education  18. Mother's Name (First, Middle, Maiden Surname)
s marked sumatic e	James Lee Bonnette  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (S	Mary Ellen Kane  Street and Number or Rural Route Number, City or Town, State, Zip Code)
or other tra	Russell C. Wolfe, Sr. (husband) 1600 Denni  20a. Method of Disposition  1 Burial 2 tremation 3 Removal from State	of Date 20c. Location - City or Town, State
Important any Injury once,	4 Donation Solution (Specify) Green Mount Cre  21. Signature of Funeral Service Licensee Mitchel  6500 Yo	matory 11-13-07 Baltimore, Maryland Address of Facility 1-Wiedefeld Funeral Home, Inc. rk Road Baltimore, Maryland 21212
sician edical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  ADENOCARCINOMA  Due to (or as a consequence of):	of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
nysician and the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the burial-transit to the buria	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	
ached for use as the bur hysicial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 5 □ Other (spec	
be det	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
page 2 should		24a. Was an autopsy prior to completion of cause o death?  1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
To the Funeral Director: After this certificate completely filled in by the funeral director, pag  Medical Certification: To Be Cor	25. Was case referred to medical examiner?  1  Yes 2 No	26. Place of Death (Check only one)  Other: 4 Nursing Home 5 Residence 6 COther (Specify) HOSPICE  Injury at Work?  1 Yes 2 No
ompletely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and due to the cause(s) and manner as stated.  In my opinion, death occurred at the time, date and place, and due to the cause(s)
comp	20B. Orginatare and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state o	29d. Date signed (Month, Day, Year)
2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.	TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 3 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death gedent's Name (First, Middle, Last) **Physician** 3-200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex **Funeral** 1□M 2**2** Days Irainia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 es 2 No Director altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2/ arleu serve by Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Manital Status 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If them 27 is marked other the any Injury or other traumant. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ NKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KliKON Ba 700 to.MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 10/01/11/01 21. Signature of Funeral Service Licenses roices 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learning the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pancreati -/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? reson or Vital Records, þ 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed | certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2∯ZINo director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE 1 ☐ Yes RZ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1√ Natural Injury 1 🗌 Yes 2 No 2 Accident Uirector: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2007

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.Tso MD Richey Hospice 838 N. Entaw St Baltimore, MD 2120

November 3, 2001

		1 - State Registrar		Cei	rtificate of L	Death		Reg. No. 2 0	07	36276
Physic	ian	Decedent's Name (First, Middle, Last)					Date of De     Month	Day	Year	3. Time of Death
/Medi	ical	MARIA W. WARE	al acceptance)		45 O't T-	Landin of Da		R 8, 20		2:40ÅM
Exami	ner	4a. Facility Name (If not institution, give street ar GILCHRIST CENTER FOR		ADE	4b. City, Town, or TOWSO!		eatn	4c. County	IMORE	ı
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 H		th	9. Birthpl	lace (State or Foreign
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/land ow at		10a. State 10b. County	10c. City	y, Town or Lo	cation				10	0d. Inside City Limits
and ZIZIS-UU3D  be filed within 72 hours after death with the Maryland tial Hygiene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	MD		BALTIM						1XYes 2 No
with t		10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
leath ns 23 must	Funeral	1103 WHEELER AVENUE  11. Marital Status  12. Was	Decedent Ever in U.	S. 13 )	212		(Specify Yes or No		SA e - America	an Indian.
or Iter		Arm	ed Forces?		Was Decedent of Hi If Yes, specify Cuba		erto Rican, etc.)		ck, White,	
5-0036 72 hours aff natural", or	by	3 X Widowed 4 □ Divorced If Year	Yes 2 🗶 No s, Give or Dates:	.   '	1 □ Yes 2 X No	Specify:		Specif	BLA	.CK
72 hg	Completed	15. Decedent's Education (Specify only highest grade comple	eted)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of v	working	16b. Kind of B	usiness/Ind	lustry
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filed v Hygie	ပ္ပိ	17. Father's Name (First, Middle, Last)		DOM	IESTIC	18. Mother's N	lame (First, Middle,		EWORK	
ld be ental ked o	To Be	HENRY PORTER					IE WINSTO		,	
shou mar mat	=	19a. Informant's Name/Relationship (Type. Print	)	19b. Mailir	ng Address (Street a				State, Zip	Code)
and 2 salth ar		HERMAN JONES/COUSIN		4416	MARRIOTS	SVILLE	RD. OWIN	GS MILL	s, MD	21117
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical	(Check only 2 Medical Examiner: On	the basis of examina manner stated.	tion and/or in	vestigation, in my o	pinion, death o	ccurred at the time,	date and place,	and due to	the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month,	Day, Year)
		pelarun			D 5	8303		Novembe	r 8	2007
2		30. Name and address of person who completed AARIN S. CHANIES	cause of death (Item	23a) (Type	Print) Nextes 5	T TOW	sin mo	21204	 t	
	ate	31. Date filed (Month, Day, Year)  NOV 1 3 2007	cause of death (Item 670) 6701 32. Regetrar's Signa	ture	Soule					
Regist	rar	MONT 9 5004	January .	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day PM 1520 2001 mne 6 November 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Bayview Medical Center N/AJohns Hopkins Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M 2 X F 74 Pennsylvania July 26,1933 177-26-1110 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 92 Kinship Road 21222 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 Ho White Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) +2 Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Visanwski John Mislan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 92 Kinship Road Dundalk, Maryland 21222 Mary McQuade (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 11/8/2007 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days Due the as a consequence of): disease or condition resulting in death) pulmonage infiltrates suspected cancer Bilateral if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE:

Examiner Examiner as the burial-transi and Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical been signature has certificate or Attending Physician: funeral director this To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death.

**Physician** 

/Medical

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he notified at

Baltimore, Maryland 21215-0036

Physician,	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		ctopic preg other (spec			2	ad. Date of delivery  Month Day Year		
by	Part II. Other significant conditions	contributing to death but not resulting in the unde	erlying cau	se given in Part I.		bacco us	se contribute to the cause of death?  No 3 Probably 4 Munknown		
Completed					24a. Was a autop: perfor	sy	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2★No		
Be (	25. Was case referred to medical			26. Place of Deat	h (Check only or	ne)			
ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3□ DOA	Other: 4 Nursing Ho	ome 5 Resid	lence 6	i □Other (Specify)		
	27. Manner of Death  1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	M 280	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	28d. Describe how injury occurred			
Certification	3 Suicide 6 Could not 4 Homicide determine		t, factory, o	office	28f. Location (S City or Tow	treet and n, State)	d Number or Rural Route Number,		
edical C		Physician: To the best of my knowledge, death of aminer: On the basis of examination and/or inve- and manner stated.							
Me	29b. Signature and title of certifier		29c. l	icense number		29d. Date	e signed (Month, Day, Year)		

Baltimore, MD 21224

November 2, 2007

State Registrar

- Mumi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aran 31. Date filed (Month, Day,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 2007 3:23 P M WEINBLATT SAMUEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE BALTIMORE BRIGHTON GARDENS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 03/10/1914 Months 1 M 2 □ F 93 MD 215-32-1409 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No BALTIMORE Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21208 2732 OLD COURT ROAD Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No WHITE Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALESPERSON 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **SPEVAK** WEINBLATT MINNIE WILLIAM ပ 19a. Informant's Name/Relationship (Type. Print)/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 SHADED GLEN COURT - OWINGS MILLS, MD. 21117 ALTMAN ANSHE EMUNAK CHAIM CONG. 20c. Location - City or Town, State BALTIMORE, MD 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/11/07 SOL LEVINSON & BROS. INC. 21. Signature of Funeral Service Li 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or is a consequence of) Sequentially list conditions, if any leading to humanistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse luence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by on cancel 1 Tes 2 No 3 Probably can cerz4a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No. Actroiency Irm Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify 1 Yes 2 Ne 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: of completely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier aber 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenetree Rd 1838 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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/Medi Examii		4a. Facility Name (If not institution, give stre 3707 Spring Meadow	et and number)			r Location of Death	1		nty of Death Howa:	_	
Funeral Director		145-10-2412	0.77	s. last birthday) 6 Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCt. 2	th 13,1911	9. Birthp	place (State or Foreign htry) NOIS	
e Maryland 8a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Howard	10c. C	ity, Town or Lo	icott Cit	У			10d. Inside City Limits 1 ☐ Yes ※ No		
th with the 23a or 2		3707 Spring Meadow	v Drive		10f. Zip Code 21 (	)42			Citizen of What Country?		
)36 irs after dea ir, or items xaminer m	by Funeral	11. Marital Status 12.  1 Never Married 2 Married 3X Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub l □ Yes 2 ☑ No		pecify Yes or No to Rican, etc.)		Race - Americ Black, White, Becify: Whi	etc.	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tall Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of word)	rking		   Kind of Business/Industry   hemical Manufactur		
ind 2 be filed trail Hygi d other event, t	To Be Col	17. Father's Name (First, Middle, Last) William A. Yeisley	, Sr.	Control Room Operator   Che						anuracturin	
		19a. Informant's Name/Relationship (Type.  Janet E. Yeisley (I	Daughter)	3707	ng Address <i>(Street</i> Spring N	Meadow Dr				,	
0 0 0 = 5		20a. Method of Disposition  1 □ Surial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	G	racelan	sition (Name of natory or other place d Memoria	al Pk 11-		Kenil	on - City or To worth,	NJ	
Baltim permit. Pag Department important: leny o		21. Signature of Funeral Service \ icensee	me	OSV   2	Name and Address Witzke Fi 5555 Twin	ineral Ho n Knolls	mes, Inc Road C	c olumbia	a, MD	21045	
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8760, cate be executed on solution and the burlal-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Nephed Due to (or as a conse	kē	Synds	me				Mouth	
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Division  To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examination)	ian: To the best of my k r: On the basis of exami and manner stated.		vestigation, în my	opinion, death occ		, date and pla	ace, and due	to the cause(s)	
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I	Examin		4a. Facility Name (If not institution, give Franklin Woods						nore	
	Funeral Director		5. Social Security Number 6. St 155-03-9191 3	7. Age (In yrs	3. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, ) Feb. 15	9. B	irthplace (State or Foreign Country) W Jersey
	ryland	_	Usual Residence of Decedent  10a. State 10b. County		City, Town or Loc					10d. Inside City Limits
	th the Ma or 28a-f s e notifies	Funeral Director	MD Balti	lmore 1	Middle	River 10f. Zip Code		10	g. Citizen of What	1 ☐ Yes 2 ☑ No Country?
	death wi	nerai [	6800 South Ri	12. Was Decedent Ever in		Vas Decedent of H	220 ispanic Origin? (Spe	ecify Yes or No-		nerican Indian,
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "netural", or Itams 23s or 28s-f show imatic event, the Madical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	Hican, etc.)	Black, WI	
21215-0036	hin 72 ho s. en "netur Mevical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4 or 5+)	(Give I		ation during most of worki	ing	Sb. Kind of Busines	
מ צונ	filed wit Hygiene other the ant, the	Be Com	17. Father's Name (First, Middle, Last)	3yrs	Med	chanic	18. Mother's Name			
Maryland	should be and Mental s markad o umatic eva	To B	Frank Yozsa  19a. Informant's Name/Relationship (7)	Time Print)	10h Mailin	a Address /Street	MArgar	et Laza		Zin Codo)
	is 1 and 2 should of Health and Men item 27 is merks other traumatic		Dorothy Coppel	1	681	19 Corne	ell Road	l Baltin	nore MD	21220
altimore,	permit. Pages 1 Department of H Important: If ite any injury or otl		20a. Method of Disposition  Disposition  Comparison Signature (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Specify Other (Spe	MC	cemetery, crem	sition (Name of natory or other place Memori	ial 11/1		Baltimor	
Ball	permit Depart Import any in		21. Sign ture of Fueral Service Licen	5 Connelly	4	Name and Address	30 Iv Funer	al Home	of Ess	alto. MD sex 21221
į	Pnysician		23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	nications that caused the dea	ath. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
H	/Medical Examiner		disease or condition resulting in death)	a CANDII	equence of):	277A	APH. IN	FECTIO	NC	
- 2	ad sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	inance of):					
8/60,	death certificate be executad e attending physician and nd for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
9	ertificate ing physi e as the l	Medicai	IF FEMALE:	23c. If yes, outcome of pregi						
O. Box	the death certific by the attending pached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		23d. Date of d Month	delivery Day Year				
rds, P.	quires that the de n signad by the a uld be detached f	by	Part II. Other significant conditions o	ontributing to death but not re		, , , _ ,	_	23e. Did toba		to the cause of death?  Probably 4  Unknown
Division of Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy perform	prior t	
Vita	Physician: The lav this certificate has al director, page 2	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatient	3 DOA Oth		n (Check only one	ce 6 Other (S	pecify)
on of	ding Phy h, After thi funeral o	tion: T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe how		
DIVISI	l or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could not be determined					28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certification the Funarel Director: After the funeral director.	Medical C	29a. Certifier Certifying Ph (Check only one) 2 Medicel Exen	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death nation and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner se and place, and d	as stated. lue to the cause(s)
	To th within	Me	29b. Signature and title of certifier	shall		29c. Licens	e number	29	d. Date signed (Mo	nth. Day, Year)
	10				эт 23a) (Туре, I	Print)	UARE	OR. BA	LTIMOR	E M.D.
	Sta Registr		30. Mame and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some and address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some address of person who some addres	32 Registrar's Sign	nature	refly				,
			110 / 4 /		- 5					

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		,	Cer	tificate of	Death			Reg. No. 2	07	362	281
0			1. Decedent's Name (First, Middle,							2. Date of De	ath	V	3. Time of I	Death
Ŀ	Physicia /Medic		Blanche	Louise	yat	25				Month 11	Day 11	2007	18:19	PM
7	Examin		4a. Facility Name (If not institution,	^		medical	4b. City, Town, o				4c. Count	y of Death		
eg sand	ale a second de como de como de como de como de como de como de como de como de como de como de como de como d			of Manyla				imo						
ŀ	Funeral Director	2	5. Social Security Number 723-07-8894	6. Sex 7. Age 1 M 2 XX	e (In yrs. Ia 80	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Jan 2,	y, Year)	9. Birthpl Count Mary	ace <i>(St</i> ate or <i>iry)</i> Iand	Foreign
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation						ad tanida Oir	. 1 ::4
	shov	'n					cation						ld. Inside City 1 ☐ Yes	
	the N 28a-f	Director	MD Prince  10e. Street and Number	George's	ьа	urel	10f. Zip Code				40= Cities= of	N// A C		A
	106. Street and Number 107. Citizen of What Co											.ry?		
	eath	era	11. Marital Status	12. Was Decedent E					igin? (Spe	cify Ves or No		ce - America	n Indian	
	r Iten	Funeral	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? ed 1 ☐ Yes 2 [X] N			Was Decedent of H f Yes, specify Cub			Rican, etc.)	Bla	ck, White, e		
ğ	al", o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2⊠No	Specify:	:		Specia	y: Whi	te	
15-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	s Education		16a. Deced	lent's Usual Occup	oation	st of workin	20	16b. Kind of E	Business/Ind	ustry	
N	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done OO NOT use retire	d)	or working	'9				
2	led w lygiel her th		12th	Ø		Home	maker	40.14-4		·=		Home		
S S	should be filed and Mental Hyg marked other matic event, i	Be	17. Father's Name (First, Middle, L Charles Col-	•				18. Moth			Maiden Surna	•		
څ	should Ind Men marke	ို	19a. Informant's Name/Relationshi			10h Mailin	- Address (C4		Mary					
Maryland 21	2 g a s		Durwood Yates/				g Address <i>(Street</i> Iunroe Ci				-	, State, Zip 21061	Coae)	
	Health Health tem 27	- 1	20a. Method of Disposition	5011	20b. Pl	ace of Dispo	sition (Name of	1		ate	20c. Location		vn. State	
<u>و</u>	Pages nent of l int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.				natorý or other pla UM Cemet	· ' :	11/16	5/2007	Scaggs	ville	- MD	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service L				. Name and Addre							
ñ	any me		bungo	ADOOK	M011		13 Talbo					20707	•	
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused	the death				-				Approximate Interval Betv	veen
	Physician		Immediate Came (Final disease or condition				tical +						Onset and D	eath
	/Medical		resulting in death)	Due to (or as a	a consequ	ence of):								
	Examiner	U	Sequentially list conditions.	b. Metab		-	20515							
	sit sed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequ	ence or):								
ð.	death certificate be executed e attending physician and id for use as the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	a consequ	ence of):								
68760,	be e sician											:		
9	ificate g phy as the	Medical		d.					-					
ROX	n cert	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1-				23d. Da	ate of delive	ry	
	deatle atte	icia	in the past 12 months? 1 ☐ Yes 2 No	1□Live birth 4□Pregnant at			]Ectopic pregnanc ] Other (s <i>pecify)</i> _	y 						ear
J Ö	requires that the death certificeen signed by the attending phould be detached for use as	Physician/	9 ☐ Unknown	9∐Unknown										
	res th igned be de	by F	Part II. Other significant condition	is contributing to death bu	ut not resu	iting in the ur	nderlying cause giv	en in Part	I.		obacco use cor			
00	w requires been sign should be	ted								10	Yes 22 No	3 ☐ Prob	ably 4 ∐U	nknown
ec C	s b	Completed								24a. Was	osy	prior to con	sy findings a	vailable use of
Vital Hecords,	That after the page	Cou								perfo 1∐ Yes	rmed? 2 X No	death?	2□ No	
	Physician: The la this certificate ha ral director, page?	Be	25. Was case referred to medical examiner?	Hospital: 🔀			Ott			(Check only o				
Ö	Phy this at d	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur		ER/Outpatien 28b. Time of		4 LJ NI			dence 6 Ot		)	
	ding in h. After funer	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Day		Injury	Wo	rk? ]Yes 2. □		.ou. Describe	now injury occu	rred		
DIVISION	Attendir death.	fica	3 Suicide 6 □ Could no	ot be 28e. Place of inju	ıry - At ho	me, farm, str	eet, factory, office			8f. Location (	Street and Num	ber or Rura	Route Numi	ber,
S	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	4 ☐ Homicide determin	building, etc	c. (Specify	')				City or To	vn, State)			
	ospit hours unera	Sal	29a. Certifier 1 Certifying	Physician: To the best of xaminer: On the basis of	of my know	wledge, death	occurred at the ti	ime, date a	nd place, a	and due to the	cause(s) and n	nanner as st	ated.	
	the H nin 24 the F	ledical	one)	and manner sta	ated.	ion and/or in			alli occurre	ed at the time,	date and place	, and due to	ine cause(s	)
	Neith Con Con	Σ	29b. Signature and title of certifier	0.1.	*		29c. Licens		, ,	,	29d. Date sign	1	Day, Year)	
			(Sanly	V. Mont	Litt			581	// /	mo	11 11	107		
	10		30. Name and address of person w	who completed cause of de	eath (item	23a) (Type,	Print)	c+ to			- IN A T	217	01	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			Greene	۳۱,۳	Just	mor	e M	410		
	Registr		E 100	9.		-1-	No.							
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				45"										

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		_	For State Registrar	State of Marylar		ertificate of		F	Reg. No. 2 (	007	36282
	Physicia	an	Decedent's Name (First, Middle, I					2. Date of Dea Month	Day	Year 2007	3. Time of Death
eq.	/Medic	al	Dorothy E. Yeage 4a. Facility Name (If not institution, g			4h City Town o	or Location of Death	NOVEMBE		y of Death	10:35 P M
	Examin	er	GREATER BALTIMOR		ER	TOWSON	or Education of Beating		BALTI	•	
	Funeral Director		166-20-3748	. Sex 7. Age (In yrs	Yre	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 03/07/	, Year)		lace (State or Foreign try) nsylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town o	Location				1	0d. Inside City Limits
	Mary I-f sho fled a	tor	MD Baltir	more P	erry :	Hall					1 ☐ Yes 2 X No
	th the or 28s e noti	Director	10e. Street and Number	IIOLC I	CITY	10f. Zip Code			10g. Citizen of	What Coun	try?
	ath wi		9316 Snyder Lan			21128			U.S.A		
	ter de Items ner m	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	12. Was Decedent Ever in L Armed Forces?	J.S.   1	<ol><li>Was Decedent of F If Yes, specify Cub</li></ol>	Hispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ha	ce - America ck, White,	
\$-0036	hours after death with the Maryland tural", or Items 23a or 28a-f show al Eximiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Spec	^{ify:} Whi	te
-	iges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hyglene.  If of Health and Mental Hyglene.  If the alten 27 is marked other than "natural", or liems 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	1 (G	ecedent's Usual Occup live kind of work done	during most of work	ing	16b. Kind of I	Business/Inc	dustry
₹ 121	within 72 ene. than "nai he Medic	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retire	ed)		O T	Tama	
E 2	filed v Hygie Sther i		12 17. Father's Name ( <i>First, Middle, La</i>	ast)	⊥_HO	memaker	18. Mother's Name	e (First, Middle,	Own F Maiden Surna		
Downtha 2121	2 should be filed and Mental Hygi is marked other aumatic event, ti	To Be	William Bird				Wilhelmi -Wilhelm	na Dun ina Du	n nn—		
ary O	2 should and Men is marke aumatic		19a. Informant's Name/Relationship	(Type. Print)	19b. M	ailing Address (Street				n, State, Zip	Code)
> °6°	1 and Health em 27 ther tr		Charles W. Year	ger (husband)	93	16 Snyder sposition (Name of		rry_Hal			21128
3.5	Pages 1 nent of H int: If ite		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	B □Removal from State	cemetery,	crematory or other pla	ice)		20c. Location	-	
₽₩	permit. Page Department o Important: If any Injury or once.	1	4 Donation 5 Other (Spe 21. Signature of Funeral Service Lie		l Air	Mem. Gdns. 22. Name and Addre		2/2007			
Ba	Departing any any once	. 1	DE RO	assahn		11750 Bela	. ننا				Home, P.A.
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the dea	ith. Do not	enter the mode of dyi	ing, such as cardiac	or respiratory ar	rest,	MI J I G	Approximate Interval Between
Cy.	Physician	1	Immediate Cause (Final disease or condition	A A	tia	1 /MPa	mono			_ 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	4.01.00	. 1 2 1	11.8	0.3		
5.0		Ē	Sequentially list conditions,	b. OGSTVU Due to (or as a conse	quence of):	CITIVIO	1 DR	unv	19	-	
	uted ansiit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Э			ate of delive Ionth	Day Year
0	The law requires that the death cer tee has been signed by the attendin age 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown							
S, P	es that gned to be deta	by P	Part II. Other significant condition	s contributing to death but not re	sulting in th	e underlying cause gi	ven in Part I.				ne cause of death?
ord	w require been signature should b	ted						1 🗆 \	Yes 2⊿No	3 Prob	oably 4 □Unknown
Sec.	has be	Completed						24a. Was autop	an 24t	. Were auto	psy findings available mpletion of cause of
a H								1□ Yes	rmed? 2 No	death? 1 ☐ Yes	2 No
Z.	Physician: this certific	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 Ampatient 2	TER/Outps	atient 3 DOA Oth	26. Place of Deat her: 4 ☐ Nursing Ho			thos (Cossif	
ō	ding Phy h. After this funeral d		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tim	ne of 28c. Inju		28d. Describe			<i>y)</i>
io	Attending r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	11100		Yes 2□No				
Division or Vital Records,	afte Dir	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 28e. Place of Injury - Att building, etc. (Spec	cify)		38	City or Tov	vn, State)		al Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my kr xaminer: On the basis of examir	nowledge, on nation and/o	leath occurred at the to or investigation, in my	time, date and place, opinion, death occur	and due to the rred at the time,	cause(s) and date and place	manner as s e, and due to	itated. o the cause(s)
	o the	Mec		and manner stated.		29c. Licen	se number		29d. Date sigr	ned (Month,	Day, Year)
	r s r o		Cuntina	Small	M	DO	05/34	7	11/8	107	7
	(D		29b. Signature and title of certifier  CUNTURA  30. Name and address of person w  CYNTURA  0!	ho completed cause of death (Ite	om 23a) (Ty	pe, Print)	navics	St. Be	MITIN	1050	MD 2/204
	Sta		31. Date filed (Month, Day, Year)	32. Pagistrar's Sign							
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**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 36283 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician 22153 PM Joanne F Yingling NOVEHBER OF 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAMARI TIMORE HOSPITAL Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) December 13 1940 9. Birthplace (State or Foreign **Funeral** Months Days Hours 217 38 0814 66 **Director** Baltimore, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 5517 Sefton Avenue Funeral 21214 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify þ Specify: White 3 ☐ Widowed 4 X Divorced Completed 7 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Accounts Payable Clerk Life Insurance Company permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Butz Frances McKenna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5517 Sefton Avenue Baltimore, Maryland 21214 Stacey A McCoy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery November 13 2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Lassann Funeral Home Inc 7401 Relair Road Raltimore, Maryland 21236 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Esquentisting list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ohysician and the burial-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deal? sign be ( 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 1 1 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral C

completely filled

> State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 13

5 Pending investigation

6 Could not be

determined

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

0017 Rh strar's Signature 32. F

and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

RES HANIA BLUD

000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) NOVEHBER 12, 2007

Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

			For Stata Registrar	State of Ma		epartment of F Certificate of		ental Hyglen Reg. N	2001	36284
I	Physici /Medic		1. Decedent's Name (First,	Middle, Last) Zu C CQri	ni		2	Date of Death Month Death	ay Year 2007	3. Time of Death
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	Funeral Director		5. Social Security Number 215-16-2118 Usual Residence of Decede	1□M 2□F	e (In yrs. last birt	hday) If Under 1 Year Months Days	Hours Min.	3. Date of Birth (Month, Day, Yea 08/03/192	r) 9. Birthp Coul	place (State or Foreign ntry) MD
	Maryland a-f show iffed at	tor	10a. State 10b. Co	ounty	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 🃉 No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 7005 Cedar Av	ve.	***************************************	10f. Zip Code 21075		10g. C USA	Citizen of What Coul	ntry?
920	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Midical Examiner is using printified at 2006.	by Funeral	11. Marital Status  1 Never Married 2 3 Widowed 4 Dive			13. Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2 ☐ No	lispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036		Completed	15. Dec (Specify only I Elementary/Secondary (0 12	cedent's Education highest grade completed)	5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire nographer	during most of working	7	Kind of Business/In	
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, Mary	and 2 should be ealth and Mental m 27 Is marked one her traumatic ev			ationship <i>(Type, Print)</i> arini / Husband	700	Mailing Address (Street 05 Cedar Ave	e., Elkrid	ge, MD 21	075	
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	Physician /Medical Examiner		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequence on the constant of the consequence on the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of	Atherosch	ng, such as cardiac or lend to C VISCQS'E	respiratory arrest,	125 CU / 92	Approximate Interval Between Onset and Death
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Ť	Sta Registr	ar	31. Date filed (Month, Day,	erson who completed cause of department of the Protest Tyear)   32. Registre   1 3 2007   2 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2007   3 2	US	Type, Print)	Caton	Ave	Baltim	- 8,2007 ore MD

Zuecarini, Doris

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mustapha Month **Physician** Zarhloul 1447 November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** John Hopkis Bayvier Medical Galtinorp CeAR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 11XM 2□ F Director 10 66 Morroeo N/AUsual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c, City, Town or Location 10b. County 10d. inside City Limits Items 23a or 28a-f showner must be notified at 1¥ Yes 2 No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 Morroeo 348 Elrino Street by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. the Medical Examiner 1√ Never Married 2 Married 1 ☐ Yes 2√ No if Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 🐒 No Specify: Specify: Asian 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ahmed_Zarhloul Zahra Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brahim Bouhmed-Brother-In-Law 348 Elrino Street, Baltimore, Md 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 11/8/07 Randallstown, Md 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. kk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Vocal Herriation **Physician** 24 HR5 /Medical Due to (or as a consequence of): Examiner INTIUCIANIAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner MEDICAL burial-tran Due to (or as a consequence of): HON APPROVED BY Division or Vital Records. P.O. Box 68760, physician Intoxica 4100 the for use as IF FEMALE 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of November 6 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X/196FF / 7 ...
31. Date filed (Month, Day, Year)
NOV 1

Registrar DHMH 17 Rev 1/2001

State

Wolfp

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vin Zimmerman		State of Maryland / Department of Health and Mental  Certificate of Death		eg. No. 20							
Physician/		egistrar . Decedent's Name (First, Middle,Last)	Date of Dea     Month	th Day Year	3. Time of Death						
edical Examiner	7	Alvin Robert Zimmerman	Month October 3	0, 2007 4c. County of Deal							
	48	4b. City, Town, or Location of De Windsor Mill		Baltimore Co	unty						
Funeral Director	5.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Min	7th(MM/DD/YYYY) 9. B Fore 26, 1951	ign MD						
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d d d d d		MD N/A Baltimore			1 Yes 2 X No						
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once, To Be Commissed by Furneral Director	1	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?						
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121 Id be fi dental narked event,		Alvin Lee Zimmerman  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number 19b. Mailing Address)			ate, Zip Code)						
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	-	Debra Zimmerman/Wife 6230 W. Canal Rd. A		yn, PA 1730	1						
re, N : 1 and f Healt ff item er trau	1	20a. Method of Disposition  Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  West Arundel Crematory 1	Date								
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr		Deposition 5 Other Specifive									
Balt permit. Depart Impor injury	i.	21. Signature of Fuperal Service Mensee  Ambrose Funeral  1328 Sulphur Spr	Home, Ind	Arbutus MD	21227						
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50, te be ex sysician burial	Nedical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del							
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Sion Attend death. ector:	catic	1 X Natural 5 Pending 2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	c. 28f. Location		or Rural Route Number, City						
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To the within. To the comple	Mec			29d. Date signed October 31,	(Month, Day, Year)						
		Que 2 O.C.M.E.		October 51,							
Ø		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201								
St Regist	ate										
DHMH 17 Rev 1/20		COMP									

			For State of Mai		artment of F ertificate of			ene 200	1 35281
-			Decedent's Name (First, Middle, Last)		Timodio or	Journ	2. Date of Death	1	3. Time of Death
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	Funeral		1⊠M 2□F	(In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
FŞ.	Director		Usual Residence of Decedent	74			April 21	,1933 Pen	nsylvania
	yland iow at			10c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Frederick	Fred	lerick				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
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	er dea Items	Funeral	11. Marital Status  12. Was Decedent Every Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
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ş	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		15. Decedent's Education	16a, Dece	edent's Usual Occup	ation	Li	6b. Kind of Business	/Industry
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7	yd wit ygien er tha er the	Con	5+		cher				Schools
and	d d d	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Surname)	
2	2 should be 1 n and Mental I is marked or raumatic eve	우	Stephen Andrus  19a. Informant's Name/Relationship (Type. Print)	401-14-11	: Add (0t	Martha	Unkr		7. 0.41
2	d 2 sl th an th an 17 is r traur		Marlene Andrus / Wife		Arbor Cou			City or Town, State, aryland 21	
ē,	tem 27 other tra		20a. Method of Disposition		osition (Name of ematory or other place			Oc. Location - City or	
e E	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Stauffer		10000		redeirck,	Maryland
Бант	# 본분증	1	21. Signature of Funeral Service Licensee					ineral Hom	
Ď	Depa Impo any it	1	A CALA						yland 21702
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not en	ter the mode of dyir	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition	ARDIAL	150	hemia			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a	consequence of):					4
	La Marine	7	Sequentially list conditions, b. LVVC	CCAAC	er				moulh.
	nsit red	nine	cause. Enter Underlying Cause (Disease or injury	consequence on.					
,	execu n and ial-tra	Examiner	that initiated events ' c	consequence of):					
00/00	tificate be executed g physician and as the burial-transit	edical	d						
	= D 6		IE EEMALG.						
Š D	ath ce trendii or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome print in the past 12 months?	f pregnancy □Fetal death 3	☐Ectopic pregnancy	/		23d. Date of de Month	elivery Day Year
5	the a	/sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti 9 ☐ Unknown 9 ☐ Unknown	me of death 5	Other (specify)			Wilditan	Day Tour
ŗ	that the set of detac		Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
ecords,	uires sign ld be	d by	Pulmonary Fi	brosis	, 111.		1 □ Ye	s 2□No 3□F	Probably 4 Donknown
5	w req	lete	1				24a. Was an	24b. Were a	utopsy findings available
ב	The la te has age 2	Completed					autopsy	prior to death?	completion of cause of
	an: rtifical tor, p	۵	25. Was case referred to medical			26. Place of Death	1 Yes 2		s 2□No
>	nyslc nis ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient	t 2 ER/Outpatie	nt 3□ DOA Oth	er: Nursing Hor	ne 5 🗆 Resider	nce 6 □Other (Sp.	ecify)
IVISION OF	ing Pl		27. Mannef of Death 1 ☐ Natural 5 ☐ Pending (Month, Day)	Year) 28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred	
2	ttendleath.	cati	2 ☐ Accident investigation			Yes 2 □ No	201 1 10		
$\leq$	or A	Certification:	4 Homicide determined building, etc.	y - At home, farm, st <i>(Specify)</i>	reet, ractory, omice	2	City or Town,	eet and Number or F , State)	turai Houte Number,
	spital ours neral rfilled		29a. Certifier 11 Certifying Physician: To the best of	my knowledge, dea	th occurred at the ti	me, date and place, a	and due to the ca	use(s) and manner a	as stated.
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only one) 2 ☐ <b>Medical Examiner</b> : On the basis of e and manner state	ed.		•			
	To the Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Compl	Ň	29b. Signature and title of certifier	UM, I	29c. Licens	e number	29	d. Date signed (Mor	oth, Day, Year)
	MI		M/ H- C. MUGITU	111	100	14107		10-29	_ 0 1
9	15×1		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type	Print)	rive . F	refleri	dy MO	2 \ 702
Ú	Sta	te	31. Date filed (Month, Day, Year) 32. Significant	's Signature	1	-			
	Registr		OCT 3 0 2007 Kenn	J. H. A.	parte				

				Please	Type or Prin							_		
			for State		State of Ma	aryland /			Health and I	Mental Hy	/giene		0.6000	
No.			1 State Registrar	ne (First, Middle, La	nst)		Ce	rtificate of	Death	2. Date of D	Reg. No	2001	35288 3. Time of Death	
	Physici /Medic		EVA CLAI	RK AUGBOR	N							ER 24, 2007 8:32A M		
	Examin	er							or Location of Death	1		County of Death		
- V.	Funeral		PRINCE GEORGES HOSPITAL CENTER  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					If Under 1 Year		8. Date of Bi	rth	PRINCE O	nplace (State or Foreign	
4	Director		244 50 3	3811	1 □ M <b>X2X</b> F	73	Yrs.	Months Days	Hours Min.	OCT. 1	2, 1	934 NOR'	TH CAROLINA	
	/land ow at	ř	Usual Residence of 10a. State	10b. County		10c. City, To	own or Lo	ocation					10d. Inside City Limits	
	e Mar 3a-f sh tiffed	Director	MD	PRINCE	GEORGES	CAPI'	TOL	HEIGHTS			XX Yes 2 □ No			
	with th		10e. Street and Nu					10f. Zip Code			10g. Citizen of What Country?			
	ns 23 must	Funeral	311 QUAI	RRY AVENU	12. Was Decedent I	Ever in U.S.	13.	20743 Was Decedent of F		necify Yes or N		ITED STA 14. Race - Amer		
35	be filed within 72 hours after death with the Maryland Hygiene.  4d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur		ried 2 Married	Armed Forces?  1 Yes X2X 1  If Yes, Give Year or Dates:	No		If Yes, specify Cub 1 ☐ Yes XXNo	Hispanic Origin? (Span, Mexican, Puert Specify:	o Rican, etc.)		Black, White		
5-0036	72 hou 'natura dical E	eted	(Spe	15. Decedent's E	ducation ade completed)	16	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry		
7	within iene. than " the Med	Completed	Elementary/Sec		College (1-4or 5	+)				ung				
0	filed v Hygie other t		17. Father's Name	(First, Middle, Las	3+		REG	ISTERED_N	NURSE 18. Mother's Nam	ne (First, Middle		GOVERN	MENT	
/lan	2 should be and Mental is marked o aumatic eve	To Be	THURMAN	CLARK					MARGAR	ET DUBL	IN			
-	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic	ľ		lame/Relationship					and Number or Ru		-			
	1 and 3 Health tem 27 other tra	- 1	JULIOUS 20a. Method of Dis	E. AUGBO	RN,JR. / S			QUARRY AV psition (Name of matory or other place)		PITOL H		TS, MD 2		
D E	Pages nent of i ant: If its any or o		XX Burial 2		Removal from State				^{ce)} ETERY 10/3	1/2007		ENTWOOD		
Salti	permit. Pag Department Important: i any injury o		21. Sign ture of F	uneral Service Lice	nsee	TORI			S FUNERAL					
	6 <b>5</b> 2 0 5		23a Part Enter	. III ou	uslications that assumed	the death D	4	308 SUITI	LAND_ROAD	SUIT	LAND	, MD 207	46	
	Physician		Immedi ne Cause	(Final	plications that caused one cause on each lin				ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
1	/Medical		disease or condition resulting in death)		a. CARDIOP Due to (or as			RREST						
3	Examiner	<u>.</u>	Sequentially list co	onditions,	b. HYPOVOL	MIC SH	OCK							
	executed n and ial-transit	Examine	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event	erlying r injury	c. G.I. BL									
oo,	be executed iician and burial-transit		resulting in death)	Last	Due to (or as	a consequenc	e of):							
	certificate b Iding physic Ise as the b	dica			d. ACUTE M	.I.								
×	eath certificate be exattending physician for use as the buria?	an/Me	IF FEMALE: 23b. Was deceder		23c. If yes, outcome 1 ☐Live birth		ath 3□	∃Ectopic pregnanc	V			23d. Date of deli	,	
5	The law requires that the death the has been signed by the atter bage 2 should be detached for u	Physician/Medical	in the past 12 1 ☐ Yes 25 9 ☐ Unknown	No	4□Pregnant at 9□Unknown			Other (specify)				Month	Day Year	
Z,	res tha signed b	by			contributing to death bu	ut not resulting	in the u	nderlying cause giv	en in Part I.				the cause of death?	
Records,	w requ	eted	END SIAC	GE RENAL	DISCASE					24a. Was		1	bbably <b>XX</b> Unknown	
1	The lar ate has page 2	Completed								auto		prior to co	topsy findings available ompletion of cause of	
VII.	iclan: certific ector,	Be (	25. Was case refe examiner?	_	Hospital:			Tout	26. Place of Dea					
5	Phys r this ral dir	- 10	1 ☐ Yes 2☐ 27. Manner of Dea		Hospital: XX Inpatie	y 28b	Outpatier  o. Time of	nt 3 DOA Oth	4 LI Nursing H	ome 5 ☐ Res 28d. Describe		6 ☐Other (Spec	eify)	
28d. Describe his large of Death Signature of Death Signature of Injury Work?  27. Manner of Death Signature of Injury Work?  28d. Date of Injury Work?  (Month, Day Year)  28d. Difference of Injury Work?  (Month, Day Year)  M 1 Yes 2 No										non injui	y cocanica			
	al or Atter des latter des la Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	e 28e. Place of injubulding, etc	iry - At home, c. (Specify)	farm, str	reet, factory, office		28f. Location ( City or To	(Street an own, State	nd Number or Ru e)	ral Route Number,	
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical C	29a. Certifier (Check only one)	XX Certifying Pl	nysiclan: To the best of miner: On the basis of and manner sta	examination	lge, deat and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	e cause(s)	) and manner as d place, and due	stated. to the cause(s)	
1	To the within To the comp	Me	29b. Signature and	title of certifier	H . M	^		29c. Licens				te signed (Month		
)			P r	Kua	m /1/1			056	464			10/25	167	
2	(10)		30. Name and add	ress of person who	completed cause of de +ri 3001 1	ath (Item 23a 405 pe to	(Type,	Dr. Che	464 everly 1	nd &	078	5		
	Sta Registr		31. Date filed (Mor	onth, Day Year) 0 2007	tri 3001 / 32. Registra	ar's Signature.	W)	,						

07-08575 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Scott R. Bittinger State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner November 4, 2007 Scott Russell Bittinger 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Cumberland Memorial Hospital Cumberland Allegany 5. Social Security Number 6. Sex If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. Foreign West 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 219-92-8774 34 Yrs 1 X M 2 F 20, 1973 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show iti Pages I and 2 should be filed within 72 hours after death with the Maryland trament of Health and Mental Hygiene trament of Health and Mental Hygiene 2 yes other transparent in the 23a or 28a-fshow y or other traumatic event, the Medical Examiner must he motived as a contract of the property of the property or other traumatic event, the Medical Examiner must he motived as a contract. Garrett Grantsville rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 3743 Chestnut Ridge Rd. 21536 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Married 2 X No Yes If Yes, Give Year Widowed 4 X Divorced Yes 2 X No specify: Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Truck Driver 17. Father's Name (First, Middle, Last) David R. Bittinger Terri S. Paul 19a. Informant's Name/Relationship (Type, Print) Terri S. Paul/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State portant: Donation 5 Other Specify 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD **Physician** failure. List only one cause on each line 1edical a, Contact Gunshot Wound of Chest Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED ned by the attending physician detached for use as the burial 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed page 2 should autopsy has performed? ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

White 16b. Kind of Business/Industry Trucking 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3743 Chestnut Ridge Rd., Grantsville, MD 20c. Location - City or Town, State Country Side CrematoryNov. 7, 2007 Davidsville, PA 22. Name and Address of Facility Newman Funeral Homes, P.A. er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? Yes 2 V No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes To the Hospital or Attending Physician: Be examiner' Hospital: 1 Other₄ DOA this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes ۵ After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self during police stand-off Nov 4, 2007 Natural 0510 hrs Yes 2 ✔ No Pendina Director: filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3743 Chestnut Ridge Road, Grantsville, MD determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 5, 2007 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 NOV Registrar DHMH 17 Rev 1/2001 OCME ORIGINAL

2007 36289

3. Time of Death

0805 hrs

Country) Virginia

10d. Inside City Limits

1 Yes 2 X No

			1 - For Stata Registrar	State of Maryla			of Health ar of Death		giene 0	36290			
	Physici /Medic		1. Decedent's Name (First, Middle, Las Carrie McNally Ba					2. Date of De Month Octobe	Day	Year 3. Time of Death 2:35 P M			
	Examir		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of		4c. County				
			Citizen's Care & Re		Center	Frede		4 Hrs   9 Date of Bir	Freder				
	Funeral Director			M 2⊠F 9			ays Hours	Min. 8. Date of Bir (Month, Da Jan 28	, 1914	9. Birthplace (State or Foreign Country) Maryland			
	D .		Usual Residence of Decedent  10a, State 10b, County	100	City, Town or Lo								
	Aaryla f ehor	ō								10d. Inside City Limits 1 🛱 Yes 2 🗍 No			
	1 the 1	rect	Maryland Frederi	CK	Frede	10f. Zip Coo	de		10g. Citizen of W	√hat Country?			
	th with	a D	1900 Rosemont Ave	nue		2.	1702		United	- 1			
	eme France	Juer	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent	of Hispanic Origin Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race	e - American Indian, k, White, etc.			
36	72 hours after deeth with the Maryland naturel', or iteme 23a or 28e-f ehow disal Examiner must be codified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☒️Widowed 4 ☐ Divorced	1 ☐ Yes 2 Mi No If Yes, Give Year or Dates:	1	1 ☐ Yes 21532				White			
21215-0036	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc	ccupation		16b. Kind of Bu	siness/Industry			
21		Completed	(Specify only highest gra	College (1-4or 5+)	1		one during most o etired)	or working					
	filed withi Hygiena, other than		17. Father's Name (First, Middle, Last)		H	lomemake		s Name (First, Middle,	Own Ho				
Maryland	should be Ind Mental I	To Be	William McNally				Fanny		Maiden Sumam	e unk.			
	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow application; other treumatic event, the Mudical Examiner must be restilled at once.		19a. Informant's Name/Relationship (7 Doris Damuth / St		19b. Maili 6024	ng Address <i>(St</i> Quinn I	Rd., Fre	o <i>r Rural Route Numb</i> derick, MD	er, City or Town, 21701	State, Zip Code)			
Baltimore,	t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐		. Place of Dispo cemetery, crei			ct. Day 0,		City or Town, State			
Ë	rtmen rtant: njury		4 □Donation 5 □ Other (Specify 21. Signature of Faneral Service Licen	Re	esthaver		1			ck, Maryland			
Ba	Depa Impo eny i		21. Signature of Pariety and Elecent	589	Ré	sthaver 01 Cato	n Funera octin Mt	l Services n. Hwy. Fr	, Skkot ederick,	Cody P.A. MD 21701			
8760,	A control of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the p	Ical Examiner	23a. Part Int the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregn: □ Other (specif)			23d. Date Mor	e of delivery nth Day Year			
	signed to	Ď	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause	e given in Part I.	23e. Did t		ibute to the cause of death?  3 □ Probably 4 □Unknown			
Records,	w requir been si should I	letec	- Marie Com	<del></del>		·							
	The lay te has	Completed							osy p rmed? d	Vere autopsy findings available of the completion of cause of leath?  ☐ Yes 2 ☐ No			
Vital		BeC	25. Was case referred to medical examiner?				26. Place o	1 ☐ Yes of Death Check only of					
of <	shys this al di	၉	1 □ Yes SV No	Hospital: 1 ☐ Inpatient 2				sing Home 5 Res					
0	ding f h. After funeri	tlon	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time o Injury		Injuryat Work? 1 ∐ Yes 2 ∐ No		how injury occurre	ad			
Division	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str					er or Rural Route Number,			
	To the Hospital of within 24 hours at To the Funerel Discompletely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of my	nowiedge, deat	h occurred at th	ne time, date and	place, and due to the	cause(s) and ma	nner as stated.			
	the Hohin 24 the Fu	Medical	one) 2 Madical Exam	iner: On the basis of exam and manner stated.	ination and/or in	vestigation, in r	my opinion, death	occurred at the time,	date and place, a	and due to the cause(s)			
	7 × 10 00		29b. Signature and title of certifier	In At.	Inni	290. Lic	cense number	02	Zya. Date signed	(Month, Day, Year)			
1	h		30. Name and address of person who	ompleted cause of death./I	tem 23a) (Type	Print)	23/2	5 > 4	Mople	27,007			
	)		HI TO HA	Tooken	30	00 W	est 9	37451	Frei	ferick mo			
	Sta Registr		31. Date filed (Month, Day, Year) 20	07 32 Registrar's Signature	mature A	ade		1					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Mary State Registrar	•	rtificate of L		-	giene Reg. No. 2	007	36291
	Physicia	ın	Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	<b>KATHLEEN DELORES BEEBE</b> 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	OCTOBE		2007 ty of Death	8:30 PM
*	Examin	er	115 DUNDEE AVENUE		CHESTER	Location of Death			EN ANN	E!C
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th		lace (State or Foreign
į.	Director		214-56-1875 1□M 2XF	60 Yrs.	Wionthio Buyo	Tiours Will.	MAY 25		MARY	
	land ow	ŀ	Usual Residence of Decedent           10a. State         10b. County         10	c. City, Town or Loc	cation				1	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notifiled at	żo	MARYLAND QUEEN ANNE'S	CHESTER						1
	or 28;	Director	10e. Street and Number		10f. Zip Code			10g. Citizen o	f What Coun	try?
	ath w		115 DUNDEE AVENUE		21619			UNITE		
	iter de	Funeral	11. Marital Status  1 ☐ Never Married  2 ▼ Married  1 ☐ Ves 2 ▼ Normal Forces?	r in U.S.   13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. R	ace - Americ ack, White,	
0030	be filed within 72 hours after death with the Marylar tall Hygiene.  id ofthe Hygiene.  id ofthe than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	<u>چ</u>	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	1	I□Yes 2XNo	Specify:		Spec	ify: WHI	TE
ה ה	72 ho 'natur dical I	Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa		kina	16b. Kind of	Business/Ind	dustry
7	within ene. than " he Mec	ğ	Elementary/Secondary (0-12)  College (1-4or 5+)	life. [	DO NOT use retired,	)	9	FEDERA		
N	filed v Hygie other t		17. Father's Name (First, Middle, Last)	COMPU	TER SPECI	18. Mother's Nam	e (First, Middle,	GOVERN Maiden Surna		
and	ld be ental ked o	To Be	WILLIAM DILLON			GLADYS D	, , ,		,	
ary	2 should be and Mental is marked craumatic ever		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a				n, State, Zip	Code)
e, Ma	1 and 2 Health eem 27 is		RUFUS BEEBE/HUSBAND		UNDEE AVE	NUE, CHE	STER, M	ARYLANI	2161	9
_	L T of BS		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place		BER 25	20c. Location	- City or To	wn, State
Баптіто	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Fuperal Service Licensee	CHESAPEAK						, MARYLAND
n n	Depa Impo any I		21. Signature of Proper agree white Elerisee	FÉ 10	LLOWS, HE 6 SHAMROC	LFENBEIN K ROAD,	AND NE	WNAM FU MARYI	NERAL AND 2	HOME, P.A.
P	RN.		23a. Part1. Enter the diseas, or complications that couls of the shock, or heart failure. List only one cause on the line.						C 1164	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a.	der co	encer, i	netasi	latic			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a co	onsequence of):	, ,		11-1			
	14.14	e.	Sequentially list conditions, if any leading to immediate b.	onsequence of:						
	d ansit	Examiner	Sequentially list conditions, if any, learling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď,	an an	Exa	resulting in death) Last Due to (or as a co	onsequence of):						
08/00	tificate be executed g physician and as the burial-transit	edical	d							
	certific nding p		IF FEMALE: 23b. Was decoded program 23c. If yes, outcome pf p	pregnancy				004.5	)	
gox	atter for u	Physician/IV	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delive Month	Day Year
	t the c by the achec	hysi	9 Unknown							
ν, T	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause give	en în Part I.	23e. Did t	obacco use co	ntribute to th	ne cause of death?
cords	require		drabetes				1 🗆	Yes 2⊅No	3 ☐ Prob	ably 4 □Unknown
ပ္သ		Completed					24a. Was auto	psy	prior to co	psy findings available mpletion of cause of
<u> </u>	icate har,	S					perfo 1⊟ Yes	rmed? 2 No	death? 1 ☐ Yes	2□ No
VITAI	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 PNo  Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatien	t 3 DOA Othe	26. Place of Dea				
0	g Phy er this eral d	ت. 1	27. Manner of Death 28a. Date of Injury	28b. Time of	1 JUDON	4 L Nursing H	ome 5 Affesi 28d. Describe			y)
0	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending (Month, Day Ye 2 ☐ Accidentinvestigation	ear) Injury		r? Yes 2 ∐ No				
UIVISION	spital or Attending Physous after death.  reral Director: After this filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc. (5	- At home, farm, stre Specify)	eet, factory, office		28f. Location (. City or To	Street and Nur wn, State)	nber or Rura	l Route Number,
ב	pital o		29a. Certifier 1 ☐ Certifying Physician: To the best of m	w knowledge, death	a coourred at the time	o data and place	and due to the	(a) and		to to d
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical								
	To th withir To th comp	Me	29b. Signature and the of certifier	1 101	29c, License	number		29d. Date sig	ned (Month,	Day, Year)
	LP		Xeren / from	- MI	DA	0210		10	25-1	0 子
	5		30. Name and address of person who completed cause of death Lestie F. B O. C. S., M.D.	h (Item 23a) (Type, I	Print) Dwens : 1	lo Rd	West	River	MA	Day, Year)  2077
	Sta	te	31. Date filed (Month, Day, Year) 32. Projector's	Signature	1 2	0 10017		, ,,	110	
	Registr	ar	OCT 2 5 2007 Marie	S & A	parke					

		1 - State of Marylai Registrar		artment of Health and f rtificate of Death		2007 36292 . No.					
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Evelyn Bernice Conn	nelly		2. Date of Death Month October	Day Year 26, 2007 1:00 PM					
Examin	er	4a. Facility Name (If not institution, give street and number) 1645 Old Westminster Pike		4b. City, Town, or Location of Death Westminster		4c. County of Death  Carroll					
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs 81 Usual Residence of Decedent	. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country) 1926 Maryland					
aryland •how	JO.	10a. State 10b. County 10c. C	ity, Town or Lo			10d. Inside City Limits  X☐ Yes 2 ☐ No					
the M	ect	Maryland Carroll  10e. Street and Number	Westmi	nster 10f. Zip Code	100	g. Citizen of What Country?					
with Pa or	ă	1645 Old Westminster Pike			109	U.S.A.					
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland if theelih and Mental Mygiene.  Item 27 is marked other than "naturel; or Items 23a or 28a-f show other treumstic event, the Mudical Examinations in stillied at	Completed by Funeral Director	11. Marital Status  1 Never Mamed 2 Married 3 Wildowed 4 Divorced  12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	}	21157 Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puertin Terrange 2 March 1 Yes 2 March Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White					
2 hou	ed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation	16	6b. Kind of Business/Industry					
12 should be filed within 72 hours aft and Abeltal Hygiens (1s marked other than "naturel; or recumatic event, the Mudical Exercitesums)	omple	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1·4or 5+)  5		kind of work done during most of wor DO NOT use retired) memaker	king	Own Home					
d 2 should be file th and Mental Hyg 7 is marked oth freumatic event,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Ma	uiden Sumame)					
uld b Wents rrked iffc	<b>10E</b>	Claude Loy		Mam	ie Beall						
2 sho and ! is m		19a. Informant's Name/Relationship (Type, Print)				City or Town, State, Zip Code) 17320					
and 2 Belth n 27		Earl W. Connelly - Son				irfield, Pennsylvania					
Page nent o ant: If ury or		20a. Method of Disposition  1 A Burial 2 Cremation 3 Removal from State 4 Definition 5 Other (Specify)		oc. Location - City or Town, State  7 Darnestown, Maryl.							
permit. Pa Depertment Important eny Injury		21. Signature of Furneral Service Consee	n 20	Name and Address of Facility 5401 Ridge Road,	s P.A., F	uneral Home , Maryland 20872					
ificate be executed by g physicien and mas the burial-transit of	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to for s a consecutive to consecutive the consecutive to consecutive the consecutive that initiated events resulting in death) Last	quence of):	liabetes	etes						
The law requires that the death certificate be executed ate hes been signed by the attending physicien and bege 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 ponths?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregrate 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?					
	Completed by	// //			24a. Was an autopsy performa	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No					
clen	Be	25. Was case referred to medical examiner?		0.1	th Check only one						
ding Phys	ation; To	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐  27. Manner ol Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	at 3 DOA Cther: 4 Nursing H 28c. Injury at Work? M 1 Yes 2 No	ome 5X Resident 28d. Describe how	ce 6 □Other (Specify) rinjury occurred						
al or Attendi s efter death. ol Director: A ad in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)							
to the Hospital or Attending within 24 hours effer death. To the Funerel Director: Affei completely filled in by the fune	Medicai	29a. Certifier (Check only one)  1 Acrtifying Physician: To the best of right one)  Medical Examiner: On the basis of examinand manner stated.	iowledge, deal! lation and/or in	occurred at the time date and place vestigation, in my opinion, death occurrence.	and due to the cau rred at the time, date	ee(e) and manner as stated. e and place, and due to the cause(s)					
To t To t Com	Σ	29b. Signature and little of certifier	tell	29c. License number  D3578	-3 Di	d. Date signed (Month, Day, Year)					
13		30. Name and address of person the completed these of death (Ite	300	Print) West 9th	St. Fr	rederick, MD					
Sta Registr	-	31. Date filed (Month, Day, Year)  32 Aegistrár's Sign	The De	and it							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 22, 2007 **Physician** MILDRED ELIZABETH CONWAY 2:03P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M XX F 16, 1927 WEST VIRGINIA 80 JAN. Director 234 46 5788 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City. Town or Location a or 28a-f show the notified at 10a. State 10b. County 10d. Inside City Limits XXYes 2 □ No Director MD HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 MacPHAIL ROAD 21014 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 200 Married 1 ☐ Yes 2XXXVo Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DISTRICT OF COLUMBIA Elementary/Secondary (0-12) College (1-4or 5+) 4+ SCHOOL TEACHER PUBLIC SCHOOLS Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM R. PALMER, SR. GENEVA (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JANET MARIA PARKER / DAUGHTER 546 DOEFIELD CT. ABINGDON, MD 21009 Baltimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) TRIANGLE, VA 4 Donation QUANTICO NATIONAL CEM. 10/30/07 21. Signature of Fineral Service sicensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC
4308 SUITLAND ROAD SUITLAND, MD 20746 INC. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cau e on each line. Immeditt Cause (Final diseased condition resultin 2 n death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No o. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2☐No 3☐ Probably 4☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ 1√0 1∐ Yes or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: All Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 ____ rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ___ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of pleat (It m 23a) (Type, Print) State 30 Registrar

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment tificate	of Health and e of Death		Reg. No		36294
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Da Month	Da		3. Time of Death
	/Medic	cal	Harriet Bernice  4a. Facility Name (If not institution, give	Coleman		4h City 1	Town, or Location of De			. County of Death	9:54 A M
	Examin	ıer	Prince George's G		al	,	verly			rince Geo	orge's
	Funeral Director		5. Social Security Number 6. Sec 579-10-2455	7. Age (In yrs.)	ast birthday). Yrs.	If Under Months	1 Year If Under 24 H Days Hours Mi	n. (Month, Da	th y, Year) 7, 1	9. Birthpl Coun 919 Virg	ace (State or Foreign try) inia
	D ,		Usual Residence of Decedent  10a. State 10b. County	10a Cib	, Town or Lo	eation				11	Od. Inside City Limits
	ed at	5								, ,	1 ☐ Yes 2 ₺ No
	the N 28s-f	Funeral Director	MD Prince G	eorges le	mple H:	111S	Code		10g. Cit	tizen of What Coun	try?
	3a or		4305 Ranger Avenu	e			20748		US	A	
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V		ent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No	-	14. Race - America Black, White, 6	
	s 1 and 2 should be filed within 72 hours after death with the Maryland It Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28s-f show other traumatic event, the Madical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		I □ Yes 2		51(6 ) 11027, 5167,			Lack
	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	kind of wor	l Occupation k done during most of w	orking	16b. K	(ind of Business/Inc	lustry
1	within sne. then	du	Elementary/Secondary (0-12)	College (1-4or 5+)	Teacl	00 NOT us	e retired)		DC	Public So	chools
3	Hygie Hygie The	ပိ	17. Father's Name (First, Middle, Last)	4 yrs.	reaci	iici	18. Mother's N	ame (First, Middle,			
) Idilia	should be ind Mental marked o umatic eve	To Be	Luther Hinnant				Hatti	e Jackson	n		
	2 shou and M is mar		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address	(Street and Number or	Rural Route Numb	er, City	or Town, State, Zip	Code)
	s 1 and 2 st Health and tem 27 is n other traun		Dr. Juanita Arche					Temple H			748
5	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	removalitotti State i	lace of Dispo- emetery, cren		1	Date		ocation - City or To	
	it. Pe rimen ritant: njury		* 4 □ Donation 5 □ Other (Specify)				metery 11-			ntwood, N	
Dairillio	permit. Peges 1 an Department of Heal Important: if item 2 eny injury or other	0.1	21. Signature of Funeral Service Licens  Pharts	hall			th Street,				20011
			23a. Part. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.					rrest,		Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition resulting in death)	FATAL CA	KDIAC	A	RRHYTHM FAILLY	1A			
	/Medical Examiner		Tooding in dealin)	Due to (or as a consequence of the second	uence of):	= A DT	- Chillis	0 ==			
Ü	2	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a consequence	uence of):	HIN!	121204				
	cuted	Examiner	that initiated events	ATRIAL T	FLUTTE	ER					
5	e exec ian ar urial-tı	Exc	resulting in death) Last	Due to (or as a consequent	uence of):						
	icate be executed physician and s the burial-transit	dical		d							
	te death certificate be executed the attending physician and hed for use as the burial-transit		IF FEMALE:	3c. If yes, outcome of pregna	nev					23d. Date of delive	
	death of atten	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pre					Day Year
,	t the d by the ached	hysi	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9☐ Unknown							
- (22)	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the ur	nderlying ca	ause given in Part I.		obacco Yes 2	use contribute to th	
	s beer s beer	Completed						24a. Was		24b. Were auto	psy findings available
:	The la	E O						auto perfe	ormed?	death?	mpletion of cause of 2□ No
		Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only	-1		
5	Physicien: r this certific ral director,	70	1 ☐ Yes 2 ☒ No	- 0	ER/Outpatien			1		6 ☐ Other (Specify	1)
:	ding P h. After t funera	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury at Work?	28d. Describe	how inju	iry occurred	
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory	1 Yes 2 No	28f. Location ( City or To		nd Number or Rura e)	I Route Number,
)	ospitel hours a uneral C ly filled i	cai Ce		sician: To the best of my kno ner: On the basis of examina							
	the H nin 24 the Fi	fedicai	one)	and manner stated				ouned at the tille,			
	To To	Σ	29b. Signature and title of certifier	// .		29c	License number	7		ate signed (Month,	-
	(2)		20 11	- facto	220/7	D-i-a) :	DO 840	/	10-	18-01	
	(5)		30. Name and address of person who co	3/0/ HICO	1+(1/	rint)	CHEVER	W mi	1 -	28-07	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ein		-/1-10/	1	, ,		
	Registr	727	DG 3 U ZUV/ /	Decline II. Da	ALIEN S						

State of Maryland / Department of Health and Mental Hygiene 200 1 - For State Registrar 36295 Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 23 12:00 P M IDA LUCY CWIEK 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death GENESIS-SPA CREEK NURSING CENTER ANNAPOLIS ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 2, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F Director 93 MARYLAND 220-30-0060 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MARYLAND QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 1303 CALVERT ROAD 21619 UNITED STATES filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Depertment of Heelth and Mental Hygien Important: if Item 27 is marked other the eny injury or other treumatic event, Ins., 2006. 6 HOUSEKEEPER/NANNY CAREGIVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN JOHN MILEWSKI URSLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DRUCILLA TOLSON/POWER OF ATTORNEY 1603 CHESTER ROAD, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State OCTOBER 27 1 YBunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 2007 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of sach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1shew **Physician** conding (dy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 21-No 1 ☐ Yes 2□ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Laursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ 110 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident ector: by the 6 Could not be 3 Suicide in by I 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Contribution Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of quitier 29c. License number 29d. Date signed (Month, Day, Year) 2036 3 10/24/701 who completed cause of death (Item 23a) (Type, Print) Mar Clistums 7118 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 5:20 PM 27,2007 DARRELL WAYNE CHILSON OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES CIVISTA PLATA CENTER MEDICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 23, 1 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1 XM 2 ☐ F 1971 Washington 562-43-6214 36 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland | Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 USA 3843 Fawn Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☐No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White カリトシのハ , リンスト (timore, Maryland 21215-00 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physically Disabled It is the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John E. Chilson Linda Dianne Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Dianne Hempel - Mother 3843 Fawn Lane, White Plains, MD 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-30-2007 Waldorf, MD **Huntt Crematory** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00053 22. Name and Address of Facility 3035 Old Washington Road Sus Laure Waldorf, MD 20601 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, in arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-tran and Due to (or as a consequence of): nding physician ause as the burial Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No detached o the 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1∏ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA P After this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P thours after death.

Uneral Director: After in the funers Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours aft To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only 2 Medical Examiner: On the basis of exa one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernando Daniels, MEDICAL STAFF SERVICES, 170 SOUTHPORT MORRISYILLE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 3 0 2007 Sparke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** JoAnn M. Croton October 26, 2007 1:04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 365-18-9845 86 Oct. 20, 1921 Director Michigan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show a or 28a-f she t be notified a 1 Yes 2 No Director Maryland Montgome ty Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3620 Littledale Road, #103 20895 USA Items 23a the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No ō 1 ☐ Yes 2 🔀 No Specify SpecifiWhite þ 3 X Widowed 4 ☐ Divorced "natural"; Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than filed within Hygiene. Keypunch Operator Ford Motor Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Menta Joseph Tucker Mary Vaderna ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Ilene J. Lineberry/Daughter 13832 Dowlais Drive, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1XDBurial 2 ☐ Cremation 3 🖾 Removal from State 2, Nov. Glenwood Cemetery 4 Donation 5 Dother (Specify) 2007 Wayne, Michigan 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner b. Small Powel Obstruction
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Colon Mass Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA ပို to Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? al or Attending F s after death. al Director: After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D63195 October 26, 2007

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

68760

Box

o

Records,

or Vital

Division

9901 Medical Center Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32: Registrar's Signature

Steven D. Wilks, MD

OCT 29

31. Date filed (Month, Day, Year)

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Maryland 21215-0036	2 6 6 6		19a. Informant's Name/Relationship (Ty) Thomas G. Carney		1	•		nd Number of et, Co			•		, ,	
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	F ₹ F 8		1 Voten				D35						r 24,	2007
	12		30. Name and address of person the co	mpleted cause of death (Item	23a) (Type,	Print)								
			Philip Henjum, MD	18109 Prince		p Dr	ive,	#200,	Olne	y, MD	2083	12		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No ZU Certificate of Death 2. Dete of Deeth 1 Decedent's Name (First Middle Last) Month Dev **Physician** 11 03 Pansy Ε. DiUbaldo 2007 6:45 P.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Alleg.
9. Birthplace (State or Foreign 105 Division St. Westernport
If Under 1 Year | If Under 24 Hrs. | 8, Date 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Hours Min Months Days 1□ M 257F Yrs. 216-22-5967 Usuel Residence of Decedent Director MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23e or 28s-f sho other traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 No MD Alleg. Funeral Director Westernport 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 105 Division St 21562 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2% No If Yes, Give Yeer or Dates: 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) David C. Ritchie Bessie Foltz 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Piedmont, WV 26750
Date 20c. Location - City or Town, State Angela Smith -Daughter 146 W. Fairview St. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 11-7-07 Westernport, MD 4 ☐ Donation 5 ☐ Other (Specify) ST Peter's Cemetery 22. Name and Address of Facility Fredlock Funeral Home 31 Jones St. Piedmont, Approximate Interval Between Oneet and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ly Examiner Examine attanding physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificata has b lirector, page 2 si 2/2 No t_Yas 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient edical Certification: To 1 ☐ Yes 2 No 3□ DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. (Check only one)

within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dis To the

> 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Rabie Zalzal 31. Date filed (Month, Day, Year) 32. Registrer's Signature

- 6

NOV

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

29c. License number

16515

Mineral & Newton Sts. Keyser, WV 26726

Registrar **DHMH 16 Rev 6/95** 

State

			For State		State of Ma	aryland	_	artment <i>rtificate</i>			nd Me		giene Reg. No.	<u> </u>	7 26200
P	-0.	超	Registrar  1. Decedent's Name	e (First, Middle, Las				imoure	0, 00			2. Date of Dea	ath	200	3. Time of Death
	Physici /Medic	_	Lorrai	ne	1	Fulle	r				C	ctober)	25	, 2007	12:00 PM
	Examin		4a. Facility Name (If	not institution, give	e street and number)			4b. City,	Town, or Lo	ocation of	Death		4c. C	county of Dea	th
100			Cherry La 5. Social Security No			/In ure Is	ast birthday)	Lat If Under	rel	f Under 24	4 Hrs G	3. Date of Birtl		ince G	eorge's
R	Funeral Director	1 1	578-30-48	1		94	Yrs.	Months			Min.	(Month, Day 8-4-19	13	Car	coline Co., VA
44	ъ	ß _	Usual Residence of	Decedent											
	arylan show d at	_	10a. State	10b. County	•		, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M 28a-f otifle	Director	MD 10e, Street and Num	Prince G	eorge's	Lau	reı	10f. Zip	Codo				10a Citiza	en of What Co	21
	with with the r	اق	12180 Dov						708				-	ed Sta	
21215-0036	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Decedent I Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S		Was Deced If Yes, spec 1 ☐ Yes 2	37	anic Origi Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)		4. Race - Ame Black, Whit Specify: <b>B1</b>	te, etc.
2-0	72 hou natura lical E	sted	(Spec	15. Decedent's Ed	lucation de completed)	Ţ	16a. Deced	dent's Usua	al Occupation	on rina most a	of working	, 1	16b. Kin	d of Business	/Industry
21	within iene. than ithe Mcc	Completed	Elementary/Secon		College (1-4or 5	+)	Domes	kind of wor DO NOT us				,	Priv	70 + 0	
121	filed w Hygie ther ti		17. Father's Name (				Domes	CIC W			's Name /	(First, Middle,			
and	be yd o	To Be		Fortune								Young			
Maryland	Sh E E	F	19a. Informant's Na	-	Type. Print)		19b. Mailir	ng Address				Route Numbe	er, City or	Town, State,	Zip Code)
	C = 0 F		Nina Edle	y( Niece	)		1218	0 Dov	e Cir	cle		rel, M			
Baltimore,	of of				Removal from State	CE	ace of Dispo emetery, crer t Linc	natory or o	therplace) Cemete	);		-2007	Bre	ation - City or	, MD
Balt	permit. Page Department Important: If any Injury o		21. Signature of Fu	neral Service Licer	nsee			2. Name an 3401	d Address o			Linco Road			Home , MD 20722
r	20.5		23a. Part1. Enter the	e disease, or com rt failure. List only	plications that caused one cause on each lir	the death	. Do not ent	er the mode	e of dying,	such as c	ardiac or	respiratory ar	rest,		Approximate Interval Between
8	Physician		Immediate Cause ( disease or condition	Final			c Lung								Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):								
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	ertifica iing ph ie as t	Med	IF FEMALE:		Ole Huge auteome	-f									
.O. Box	at the death certifi by the attending tached for use as	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown		23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal	death 3[	∃Ectopic pro ∃Other (sp					23	3d. Date of de Month	Day Year
Δ.	The law requires that the ate has been signed by the bage 2 should be detache	by Pt	Part II. Other signif	ficant conditions	ontributing to death b	ut not resu	Ilting in the u	nderlying ca	ause given	in Part I.		23e. Did to	obacco us	e contribute t	o the cause of death?
ıdş	equire en sig ould b		_Pulmonar	y emboli	sm, Hypert	ensi	on, An	emia				1 🗆 1	Yes 2□	]No 3∏P	robably 4\sum_Unknown
Records,	law requas been 2 should	Completed	Failure	to thriv	e							24a. Was		24b. Were a	utopsy findings available completion of cause of
<u> </u>		Som										perfo 1∐ Yes	rmed? 2 No	death? 1 ☐ Ye	·
Vital	Physiclan: The this certificate ral director, pag	Be	25. Was case reference examiner?		Hospital:							(Check only o			
o	Phys this ral di	은	1 A Yes 2 ☐ 27. Manner of Deat		1 ☐ Inpatie		ER/Outpatier 28b. Time o		8c Injury a	4⊡ Nurs		ne 5 Resid			ecify)
	Attending F r death. ector: After by the funer	tion	1 Natural 2 Accident	5 ☐ Pending investigation	(Month, Da	y Year)	Injury	М	8c. Injury a Work? 1 □ Ye	es 2∐N				0000,100	
Division	ospital or Attend hours after death uneral Director: , iy filled in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju- building, et	ury - At ho c. <i>(Specify</i>	me, farm, str	reet, factory	, office		28	8f. Location (8 City or Tov	Street and vn, State)	Number or F	lural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Chack only one	1XXCertifying Ph 2☐ Medical Exar	nysician: To the best niner: On the basis o and manner sta	f examinat	wledge, deat tion and/or in	h occurred vestigation	at the time, in my opir	, date and nion, deatl	d place, a th occurre	nd due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. te to the cause(s)
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and	title of certifier	A	TTE	NDIN	C, 290	. License n				29d. Date	signed (Mon	th, Day, Year)
			Sm	-0	mo PH	7510	IAN		00	05	72	16	OCT	27,	2007
1)	(3)		30. Name and addr	ress of person who	completed cause of d	eath (Item	23a) (Type,	,							<del></del>
1			Michael 31. Date filed (Mon	Baako, l	MD 3450	Fort	Meade	Road	# 20	9 La	ure1	, MD 20	0724		
	Sta Regist		OCT 3		32. Registr	ar a digital	ed								

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mont)

9 2007

DHMH 17 Rev 1/2001

Megistrar's Signature

zene St

Baltimore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Guthrie, <u>Sr.</u> James 01 07 11 0743 Franklin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** WMHS Braddock Campus **Allegany** Cumber Land 8. Date of Birth (Month, Day, Year) Sept. 11, 1934 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Mìn. 1[**X**M 2□ F West Virginia 220-32-2695 73 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Garrett Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Valley View Lane 21532 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █****No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Route Salesman Dairy permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenn Guthrie Grace Sisler ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian S. Guthrie/Wife 7 Valley View Lane, Frostburg, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery Nov. 4, 2007 Frostburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. J euman P.O. Box 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only/one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) MYOCARDIAL ACUTE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 physician the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an page 2 s certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA ဥ this After th funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 @'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zamar 904 Seton Drive Cumberland Maryland 21502 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 24 12:54 P M OCTOBER GRIFFITH LINDA LILLIAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 🕅 56 Maryland Director 215-56-9134 July 15, 1951 Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Frederick Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 21702 United States 8726 Indian Springs Road items 23a Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 X Married Specify: White 'natural", or 1 ☐ Yes 2 🛣 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Biotechnology Accountant i 2 should be filed whand Mental Hygier is marked other the permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Edenton Walter Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8726 Indian Springs Rd. Frederick, MD 21702 19a. Informant's Name/Relationship (Type. Print) Harold Griffith / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 27, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Frederick, Maryland 21. Signature of Fureral S Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence f): hours Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transi Non Hodekeis Due to (or as a consequence of). signed by the attending physician the detached for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 7 No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hepatitis C 1 Yes 2 No 3 Probably 4 Wonknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 3 No 1 1 Impatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 66166

Oi

Saltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division or Vital Records,

State Registrar Muduson Raza
31. Date filed (Month, Day, Year)

OCT 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Memorial Nospital
32. pegistrar's Signature

Signature

Signature

7 M Street. Fredrick MB

07-08278

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

enda F. Gordo	1	1- For State Registrar Certificate of Death		Reg. N	lo. <u>20</u>	7. 2.00	
Physicia edical Examir	ın/	1. Decedent's Name (First, Middle,Last) Lorenda Doreen Fambro Gordon		2. Date of Death Month Da October 24, 2	y Year 2007	8. Time of Death 3	
بر لا		4a. Facility Name (if not institution, give street and number)  4b. City, Tor  Prince George's Hospital Center  Chever	wn, or Location of Death	00(000) 21, 2	4c. County of Death Prince George	's	
Funeral Director		5. Social Security Number 199-50-3762 6. Sex 7. Age (In yrs. last birthday) If Under Months	1 Year If Under 24Hrs. Days Hours Min.	8. Date of Birth (N	Foreig	hplace (State or n untry) PA	
Maryland 28a-f show any <u>d at once.</u>		Usual Residence of Decedent  10a. State		140-	ber, City or Town, State, Zip Code) 34113  20c. Location - City or Town, State Clinton, MD  Johnson Funeral Home, Pemple Hills, MD 20748  est, shock, or heart Between Onset and Death  23d. Date of delivery Month Day Year		
the Mary is or 28a-	Dire	10e. Street and Number 12206 Quick Fox Lane 207		_		ntry?	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify 1 Yes 2 No HYes, Give Year or Dates: If Yes, Specify 1 Yes, Give Year or Dates:	t of Hispanic Origin? (Sp. Cuban, Mexican, Puerto I	Rican, etc.)	White, etc.  Specify: Bla	ck	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Itant: If iten 27 is marked other than "natur or other traumatic event, the Medical Exami	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+) 5+  Special Education  Special Education  Special Education  College (1-4 or 5+)	ing life. DO NOT use retir	ed)		ndustry	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical	Be	17. Father's Name (First, Middle, Last) Lorenzo D. Fambro	LaVerne	(First, Middle, Maio		Zin Code)	
MD 2 d 2 shoul lith and M n 27 is m aumatic	٢	LaVerne Franklin - mother 7005 Kiwi I	Place, Naple	es, FL 34	113		
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name crematory or other place)  Resurrection Co			· ·		
Balt permit. Depart Import injury		21. Signature of Funeral Service Lidensee 22. Name and A	d Branch Ave	nue Tem	nle Hills	, MD 20748	
Physician /Medical *xaminer	2 1	28a/Part I. Enter the disease, of omplications that caused the death. Do not enter the mode of failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	r dying, such as cardiac o	r respiratory arrest,	SHOCK, OF HEAR	Between Onset and	
.*	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
ecuted and transit	al Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal - transit		UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown   1 Unknown   2 Fetal death   5 Other (Spec	3 Ectopic pregna	ancy			
, P.O. Bo) rres that the deatl signed by the att	δ	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.			the cause of death?	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the starter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detected.	Completed			24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of fee 2 No	
ital Rec sician: The s certificate irector, page	Be	examiner? Hospital: 1 Innation: 3 FR/Outnation: 3 D	26.Place of Death (Check DA Other Nursin		esidence 6 Othe	er:	
on of Virulating Physicath.  or: After this he funeral dir	tion: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Menth Day Year)  1 1410 hrs	8c. Injury at Work?  1 Yes 2 No	28d. Describe ho Driver auto bu			
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral	Certification:	2 M Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street		or Town, Sta		tural Route Number, Cit Bowie, MD	
To the Hospital within 24 hours To the Funeral completely filled	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the cone)  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	time, date and place, and opinion, death occurred . License number	at the time, date ar	s) and manner as stand place, and due to a 29d. Date signed (M	the cause(s)	
	Σ	Donna MU moenti, M.D.	O.C.M.E.	}	October 25, 200		
(10)			Street, Baltimore, N	/ID 21201			
S Regis	tate trar	A A DOOL IN TO THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF					
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		For 1 _ Stata		epartment of Health and I	Mental Hygiene	2007 26205
		Registrar  1. Decedent's Name (First, Middle, Kas		Certificate of Death	Reg. No.	2007 36305
Physi /Med		150n C	hordon, Ji		Month Day	3 897 5:03 am
Exam	iner	(4a) Facility Name (If not institution, give	streef and number)	4b. City, Town, or Location of Death	46.	. County of Death
Funera Directo		5. Social Security Number 6. S 256 54 600 1	THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE ATTENTION OF THE AT	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 5 15 19 3	9. Birthplace (State or Foreign Country)
land bw		Usual Residence of Decedent  10a. State 10b. County	2 10c, City, Town	or Location		10d. Inside City Limits
with the Maryland is or 28a-f show	ector	DE New (	Castle Wil	minaton	10g Cit	1 ■Yes 2 □ No
s 23s or	Funeral Director	2615 Vess	up Street	19802		ISA
I 3-UU30 n 72 hours after death with the Marylan "netural; or Items 23a or 28a-f show colosi Exardi at mast be notified at	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
72 hou	Completed	15. Decedent's Ec (Specify only highest gra	de completed) (	Decedent's Usual Occupation (Give kind of work done during most of work life., DO NOT use retired)	rking 16b. Ki	(ind of Business/Industry
be filed within tal Hygiene. Ind other then 's event, Ins Me	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Chine Operation	or Ci	ty of Wilmingto
0 2 0 0	To Be C	17. Father's Name (First, Middle, Last)	don	18. Morfier's Nar	ne (First, Middle, Maiden	Surfame)
re, maryla s 1 and 2 should f Health and Men item 27 is merks other traumatic		19a Informant's Name/Relationship (	Type, Print) 19b. I	Mailing Address (Street and Number or R	ral Route Number, City o	or T. wn, State, Zip Code)
		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	Disposition (Name of crematory or other place)	I I I I I	ocation - City or Town, State
를 발된 문을	9	^ 4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Lice		22. Name and Address of Facility	18107 N	71111, 00
D ed de de de de de de de de de de de de	8500 8000	23a. Por 11. Enter the disease, or com-	heations that on sed the search in no	CONG TUNEYAL H	m, P.O.60	Approximate
Physician	n	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	Sotructive Pulmo		Interval Between
/Medica Examine		resulting in death)	Altono Col	Protie Heart Dise	ase	yeary
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	():		yo.
be executed be executed ician and burial-transit	ai Exar	that initiated events resulting in death) Last	Due to (or as a consequence of	():		rears
<b>68 / 6U</b> , ificate be e.g. physician as the buria	.0		d			•
BOX 68/     death certificate the attending physical for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
vequires that the deben signed by the	by Phy	Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
COTGS, w requires t been signe should be o		Chronie	kidney disease	2	1 ☐ Yes 2	No 3 Probably 4 Minknown
The lay	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
VITAL H sician: The certificate h irector, page	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one)	
Jn Or ding Phys After this funeral di	tion: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Ti		dome 5 Residence 28d. Describe how inju	
	ertification:	3 Suicide 6 Could not b 4 Homicide determined	8 29a Place of Injury At home for	m, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, te)
To the Hospital or within 24 hours after To the Funeral Dis completely filled in	edical C			death occurred at the time, date and place for investigation, in my opinion, death occ		
To the within To the comple	Me	29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, Year)
		1 Herelia	Zer SMD	20023322		10.30.2007.
		30. Name and address of person who	completed cause of death (Item 23a) (TAD , 118 North	St Suit 3B EC	Elm MD 21	1921.
S Regi:	State strar	31. Date filed (Month, Day, Year)	2007 Signature	Type. Print)  St Stute 3B EC		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** October 29, 2007 A M REDA MAY GORDON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Southern Maryland Hospital Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 25, 1911 9. Birthplace (State or Foreign Country)
Virginia 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months 1 M 2 X F 579-66-1362 95 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Charles Maryland Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12160 Ell Lane, Apt. 114 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or Itel 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Painter ဥ **Eunice Henry** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum once. 12160 Ell Lane, Apt. 114, Waldorf, MD 20602 Robert C. Edwards - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Suitland, MD Washington National 11-1-2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M00053 Waldorf, MD 20601 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🕱 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 😿 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural n 24 hours after death.

Re Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) WE CENTER WALDONE, and, 20602 场的 WISOTSCE 31. Date filed (Month, Day, Year) OCT 3 0 State Registrar

		_	For State Registrar	State of Ma	aryland / De <i>C</i>	partment e <i>rtificate</i>			-	giene	007	36307			
144	Dhysisi		1. Decedent's Name (First, Middle, La	ist)					2. Date of De		Year	3. Time of Death			
	Physici /Medic		WILLIAM GINDES						OCTOBE			12:21 A M			
	Examir	er	4a. Facility Name (If not institution, give			4b. City, To		ocation of Dea	ith	4c. (	County of Dea				
- t-	funcial.		MONTGOMERY GENER  5. Social Security Number 6.		B (In yrs. last birthda	lf Under 1	OLN:	E <b>Y</b> f Under 24 Hr	S. 8 Date of Bir	th.		TGOMERY			
	Funeral Director			1 🛣 M 2 🗆 F	78 Yrs.			Hours Mir		у, _{Уваг)} 1928	WA	rthplace (State or Foreign ountry) SHINGTON, DC			
	pu ,		Usual Residence of Decedent  10a. State 10b. County		40. 02. 7										
	shov	5			10c. City, Town or							10d. Inside City Limits 1X Yes 2 ☐ No			
	28a-f	Director	MARYLAND MONTGO	MERY	ROCKVILL	E 10f. Zip C	'orle			10g Citis	zen of What C				
	death with the Maryland rime 23s or 28s-f show		14235 CHADWICK L	ANE		101. 2100		0853		109. Olliz		.S.A.			
	death	Funerai	11. Marital Status	t2. Was Decedent I	Ever in U.S. 1	3. Was Decede	nt of Hisp	anic Origin? (	Specify Yes or No	)- 1	14. Race - Am	encan Indian,			
36	or ite		1 ☐ Never Married 2 📉 Married	1 Yes 2 1	40	1 ☐ Yes 2		Specify:	no Alcan, etc.)		Black, Whi	ite, etc.			
21215-0036	fure!	ed by	3 ☐Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	10- D-						W	HITE			
15	in 72 n "na	Completed	(Specify only highest gr	ade completed)	(G.	cedent's Usual ve kind of work b. DO NOT use	done dur	ing most of w	orking	166. Kir	nd of Business	s/industry			
212	d with giene	E O	Elementary/Secondary (0-12)	College (1-4or 5	+)	OWNER				В	EAUTY	SALON			
nd	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "naturel", or iteme 23a or 28a-1 show aumatic event, the Madical Exteniner mant be notified at	Be (	17. Father's Name (First, Middle, Last	")			11	8. Mother's Na	ame (First, Middle	, Maiden :	Sumame)				
yla	Men Men	ျ	PHILIP GINDES					ANNIE S							
Maryland	d2st thanc traun		19a. Informant's Name/Relationship BARBARA GINDES -	er, City or LE, M	Zip Code) D 20853										
a)	ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental Hygtene. If item 27 is marked other then "naturel", or iteme 23s or 28s-f show or other traumatic event, the Medical Exterinat matal be notified at		20a. Method of Disposition		cation - City or										
Ê	Page: sent o nt: #		1 X Burial 2 ☐ Cremation 3 E 4 ☐ Donation 5 ☐ Other (Speci	FALL	S CHUR	CH, VIRGINIA									
Baltimore,	permit. Pages: Department of I- important: If its eny injury or ot		21. Signature of Funeral Service Lice												
8	89 = 8		(0)			1091 RO	CKVII	LLE PIR		ILLE	, MARY	LAND 20852			
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximate Interval Between												
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Illinediate Cause (Final											
	Examiner		1	Due to (or as	a consequence of):										
0	÷	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):										
15	cuted nd ransit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c											
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8760	icate be executed physician and s the burial-transit	dicai	•	d						-					
9 x 6	death certifi e attending I d for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						2d Data of de				
Вох	death s atter d for u	iciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 □Ectopic pred 5 □ Other (spec				-	3d. Date of de Month	Day Year			
P.O.	by the	hys	9 Unknown 9 Unknown												
	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	۾	Part II. Other significant conditions ACUTE MYOCARDIAL				to the cause of death?								
of Vital Records,	w requ	Completed							24a, Was						
Re	The law te has age 2 s	omp							auto	psy omed?	prior to death?	utopsy findings available completion of cause of			
ita	oertificate rector, pag	0	25. Was case referred to medical				2	6. Place of De	1 ☐ Yes eath (Check only o		1 Ll Yes	s 2□No			
) \	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1 ☑ Inpatie	nt 2 ER/Outpat	ient 3 DOA	-		Home 5 Resi		Other (Spi	ecify)			
o Lo	ding P h. After t funera	on.	27. Manner of Death 1 ☒Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injur		c. Injury a Work?	t	28d. Describe						
Division	Attending ir death. ector: After by the fune	Certification.	2 ☐ Accident investigated 3 ☐ Suicide 6 ☐ Could not t	00 Diago of lais	ury - At home, farm,	M street factors		s 2 No	29f Location (	Ctroot and	Alumbasas	Rural Route Number.			
οįς	after after Dire	erti	4 Homicide determined	building, etc	c. (Specify)	street, ractory,	OHICO		City or To	wn, State)	Number of A	nurar noute ivumber,			
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	hysician: To the best of	of my knowledge, de	ath occurred at	the time,	date and place	e, and due to the	cause(s)	and manner a	es stated.			
	the Hin 24 the Fi	Medical	51.07	miner: On the basis of and manner sta	examination and/oi	investigation, in	n my opin	ion, death occ	curred at the time,	date and	place, and du	e to the cause(s)			
	5 mg 2 mg	2	29b. Signature and title of certifier	1 10			License n 42452				signed (Mon BER 27	nth, Day, Year)			
•	6		Chihe	This	re		T471	<u>-</u>		0010	DEK Z/	, 2007			
			30. Name and address of person who DR. CHITRA RAJAG	// //			ייזדקח	- #20=	7 OTNEV	MAD	VIAND	20822			
30	s & Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature		NVTAI	11321	, ULNEY,	MAK	LLAND	20832			
	Registr	100	UG1 2 9 2	307 Janeur	J. K.	perte									

		Please Type or	Print in Black In	delible Ink.	Ensure All	Copies Are	Legible.	
		_ 101	of Maryland / Dep					0.000
		1 - State Registrar	Ce	rtificate of l	Death	Reg. N	2007	36308
Physicia	an l	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	ay Year	3. Time of Death
/Medic		Milton Sylvester Hall				itober 1	9,2007	11:40 AM
Examin	er	4a. Facility Name (If not institution, give street and no VA Maruhma Health Care		4b. City, Town, or	Location of Death	4	c. County of Deat	n
Funeral	46	Social Security Number	7. Age (In yrs. last birthday	If Under Mear		8. Date of Birth	9. Birt	thplace (State or Foreign
Director		217-20-9751 ^{1⊠M 2□F}	81 ^{Yrs.}	Months Days	Hours Min.	(Month, Day, Yea ) ct. 04. 1		uikand
pur w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
Aaryla f sho	o							1 □Yes 2 X No
the N 28a- notifi	Director	Maryland Cecil  10e. Street and Number	Perry Pe	10f. Zip Code		10g. C	Citizen of What Co	puntry?
after death with the Maryland or Items 23a or 28a-f show miner must be notifled at	Ö	Perry Point VA Medical	Center	2190	7	u.s	A	
deatl	Funeral				ispanic Origin? (Spe an, Mexican, Puerto F		14. Race - Ame Black, White	
after or ite		1 X Never Married 2 Married 1 X Yes If Yes, G	^{2□No} 1945 -	1 ☐ Yes 2 ☑ No	Specify:	noun, oto.,	Specify: 32	
hours tural"	d by	3 ☐ Widowed 4 ☐ Divorced Year or	1740	donto Housi Occur	otion	16h	Kind of Business/	
in 72 "na" r	olete	15. Decedent's Education (Specify only highest grade completed	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of workir d)	ng   160.	Killd of Business/	moustry
y with giene. r thar the N	Completed	Elementary/Secondary (0-12) College Unknown	(1-4or 5+)	bled Labor		1	sabled	
al Hyg othe	BeC	17. Father's Name (First, Middle, Last)	·		18. Mother's Name	(First, Middle, Maide	en Surname)	
Menta Menta arked	2	William Hall, Jr.			Beulah H	lall		
2 sho		19a. Informant's Name/Relationship (Type. Print)			and Number or Rura	-		
1 and Health em 27 ther to		Amy Saylor (Social Works 20a, Method of Disposition		Point VA	A Medical	Center Pe	rry Poin	t, MD 21902 Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 □ Cremation 3 □ Removal from	n State   cemetery, cre	ematory or other plac	ce) ;			
artme artme ortant injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signeture of Funeral Service Lice See	Garrison		ss of Facility Proces	12001 0000	ngs much	s, Maryland uneral Home
Depi Impo		) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> ) <del>(</del> 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Wash	rington St	Haune d	o Graco	MD 21078
VANCE OF		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on					e orace,	Approximate Interval Between
Physician				rostate	/\			Onset and Death
/Medical		resulting in death)	o (or as a consequence of):	residic		,		-11/01110
Examiner		Sequentially list conditions, b.						
ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):					
be executed cian and ourial-transit	Examiner	triat initiated events	(or as a consequence of):					
e be e		C _d						
tificate big physical	edi							
The law requires that the death certificate it has been signed by the attending physinage 2 should be detached for use as the t	Physician/Medical	23b. was decedent pregnant	utcome pf pregnancy	□Ectopic pregnancy	,		23d. Date of de	
e dea	sicia	1 Yes 2 No 4 Pre	gnant at time of death 5	Other (specify)			Month	Day Year
nat the de d by the etached	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to		undorlying cause aiv	on in Part I	23e Did tobacc	n use contribute to	o the cause of death?
		Dementia.	dealth but not resulting in the t	andenying cause givi	en ni ranti.			robably 4 Unknown
w requir been si should l	Completed by	Derrorring						
The law	mp					24a. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
		25. Was case referred to medical			26 Place of Death	1  Yes 2 2 1 1	No 1 □Yes	2 X No
ysician: s certific director,	To Be	examiner?	Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing Hon	ne 5 Residence	6 ∏Other (Spe	ecify)
ig Phys ter this neral dir			e of Injury 28b. Time onth, Day Year) Injury			8d. Describe how in		
endin eath. or: Af he fur	Certification:	2 Accident investigation	, and , but , but , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and , and		Yes 2 □ No			
or Att ter de lirect n by t	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buil	ce of injury - At home, farm, s ding, etc. <i>(Specify)</i>	treet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rate)	ural Route Number,
pital of urs all praises all praises all illed i		Continue 174 Continue Dharing To the		Al	data d		(-)	1
Hos 24 ho Fun etely 1	edical	29a. Certifier 1 Certifying Physician: To the (Check only one) 1 Medical Examiner: On the						
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Med	29b. Signature and title of perfilier	-/1 1	29c. Licens	e number	29d. [	Date signed (Moni	th, Day, Year)
- > - 0		1 /kn/2 (+1)	the Man	Da	2390	m.	tohod	9 2007
		30. Name and address of person who completed car	use of death (Item 23a) (Type  Registrar's Sonature	, Print)			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1,001
		Charles Hoesch, M. D., Y	A Maryland He	alth Care	System, P	erry Poir	J+mo :	11902
Sta	te	31. Date filed (Month Day Year) 1 2007 32.	Resistrar's Signature	South	,	5	1	

Year

3. Time of Death

Rag. No.

2. Date of Death

Month

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** Herbert October 25, 2007 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Yrs. 50 Director 112-62-8049 Oct. 24, 1957 Trinidad Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits rai', or iteme 23a or 28a-1 show Examiner must be notified at MD Prince George's Hyattsville 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 1920 Dana Drive USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed The Mudicul 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill nt of Health and Mental H: If Item 27 is marked oth Be is marked of William Herbert Emelda Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Brenda Nurse/Sister 3813 Ferrara Dr Silver Spring, MD or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If eny injury or QDGE. 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem.10-31-2007 Adelphi, MD 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th Street, NW Washington, DC Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** maio myo /Medical Due to (or as a consequent Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner use as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 21 No Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 K No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title ertite 29c. License number 29d. Date signed (Month, Day, Year) D4566 30. Name and add so of paor in who completed cause of death (Item 23a) (Te, Print) 14300 GALENT FOX LN. BEWIE, MD. 20715 DR. DRINGER Registrar's Sign 31. Date filed (Month, Day, Year)
OCT 3 0 2007 State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Frederick

10f. Zip Code

21701

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Sept. 9, 1

Sept.

Frederick

10g. Citizen of What Country?

14. Race - American Indian

Black, White, etc.

U.S.A.

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Maryland

**Physician** /Medical Examiner

**Funeral** 

5. Social Security Number

Maryland

11. Marital Status

10e. Street and Number

10a. State

Director

214-10-1058

Usual Residence of Decedent

10b. County

6. Sex

Frederick

206 West 12th Street

1 □ M XXX

7. Age (In yrs. last birthday)

10c. City, Town or Location

Frederick

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed attending physician the or Attending Physician: ours after death.
neral Director: A To the Hospital of within 24 hours at To the Funeral D

Division or Vital Records, P.O. Box 68760,

Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White ò Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Electronics Person 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard V. Strine Cora R. Rice 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8131 Runnymeade Drive, Frederick, MD 21702 Robert W. Keeney, son 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Mount Olivet Cemetery Oct. 31, 2007 Frederick, MD 4 Donation 5 Dother (Specify) 21. Signature of Fun cal Service Licen ²².Keene∀dandFBäsford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kenal Harure disease or condition resulting in death) Due to (or as a consequence of): MH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent prognant in the past 12 ponths?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) October 29, 2007 D 40307 asay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene B./Casagrande, M.D., 1564 Opossumtown Pike, Frederick, MD 21702

State

Registrar

31. Date filed (Month, Day, Year)

OCT 3 0 2007

32. degistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 36312 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** EVELYN FRANCES OHLHEISER KOHL OCTOBER 21, 2007 3:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HARBORSIDE HEALTHCARE CENTER BOWIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 💢 F 91 MARCH 13, 1916 252-01-4254 **NEW YORK** Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2X No by Funeral Director MARYLAND QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 UNITED STATES 1700 MIDWAY ROAD 21619 death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 ₩idowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Pages 1 and 2 should be filed v iment of Health and Mental Hygie tant: if Item 27 is marked other t ijury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDWARD OHLHEISER FLORA RUSSELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GARY D. KOHL/SON 1700 MIDWAY ROAD, CHESTER, MARYLAND 21619 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition OCTOBER 25 1 Burial 2 Cremation 3 Removal from State Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) SOUTH WALES CEMETERY 2007 WALES, NEW YORK 21. Signature of Funeral Service Lice Fe 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** coronan year's /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and physician and s the burial-transit Due to (or as a consequence of) Box 68760. Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 1 ☐ Yes 2 1 No 9 ☐ Unknown 4☐Pregnant at time of death signed by the a 5 Other (specify) o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2√2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: ٤ 1 ☐ Yes 2 No 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the 3 🖺 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 laying and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallast Forlame it 10 ciches BOWIE 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:30 p M October 24, 2007 Frances Kanter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Potomac Montgomery Liberty Assisted Living Group Home 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days 1□ M 2√ F 140-09-9937 98 03//10/1909 Lithuania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be accounted. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County Y⊟Yes 2□No Director Md. Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8919 Liberty Lane 20854 US by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Retail Women's Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Cutler Helen unobtainable ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8730 Hickory Bend Trail Potomac, Md. 20854 Harriette Adler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Star of David 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State N. Lauderdale, Fl. 10/28/07 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Danzansky-Goldberg Memorial Gardens
1170 Rockville Pike Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner b. Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner death certificate be executed Diabetes Mellitus the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at d be detached fo 1□Yes 2√xNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 【XNo 3 ☐ Probably 4 ☐ Unknown Dementia- Vascular Type Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dther (Speci@roup Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature D35579

Registrar DHMH 17 Rev 1/2001

State

Susan J. Miller 8218 Wisconsin Ave. Suite 305 Bethesda, Md. 20814

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 9 2007

31. Date filed (Month

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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location						10	Od. Inside City Limits
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	1 the	Director	10e. Street and Number			10f. Zip	Code				10g. Citizen of V	What Coun	try?
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9	int. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hygiene.  criment of Health and Mental Hygiene.  rathert: if term 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I'm Medical Examinar must be notified at the second of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro	/ Funeral	1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		13. Was Decede		panic Origi , Mexican, Specify:	in? (Specif Puerto Ric	fy Yes or No- can, etc.)	Blac	e - America ck, White, e	etc.
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Baltimore, Maryland 21215-0036	d 2 should be th and Mental th smarked ( traumatic ev		19a. Informant's Name/Relationship (Ty	pe, Print)		. Mailing Address							^{Code)} 6764
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Balti	permit. Pages Deportment of Important: if i any injury or o		21. Signature of Funeral Service Licens	Buda	k	22. Name and	Address	of Facility,	aht	Fune	ral Ho	me ta, '	WV 26764
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	ing P	on:	27. Manner → Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	njury	3c. Injury a Work?	?		d. Describe h	ow injury occur	red	
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É	or An	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	y - At nome, ta (Specify)	.rm, street, !actory,	office		281	City or Tow		er or Hurai	i Route Number,
_	e Hospital 24 hours a e Funeral letely filled		29a, Certifier 1 Certifying Phys	sician: To the best of	my knowledge	a, death occurred a	it the time	e, date and	place, and	d due to the	ause(s) and ma	anner as st	ated.
	I o the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Examination)	ner: On the basis of e	examination an	d/or investigation,	in my opi	nion, death	occurred	at the time, o	late and place,	and due to	the cause(s)
	within 24	Me	29b. Signature and title of certifier		/	29c.	License	number		:	29d. Date signe	d (Month, (	Day, Year)
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		1 A	30. Name and address of person who co					, ,		,	10:0		
		10	Softere Savopoula			Fourth St.	, 541	k/,	Oakla	and, I	ND 2	1550	J
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	A Company	J.						

Marijke S. Mc Mahon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene JNK UNK 2007 363 15 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day October 26, 2007 0039 hrs ¬I Examine Marijke S. McMahon 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick **New Market** 6661 Harbor Light Way Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Min Days Hours Months Aug. 30 1981 Country) Maryland Director M 2XF 26 220-13-4833 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 X No New Market or items 23a or 28a-f show must be notified at once. Frederick hours after death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 21774 6661 Harbor Light Way 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married Never Married 2 X No White Yes Specify 1 Yes 2 X No specify: If Yes, Give Yeer Divorced Widowed event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) wit. Pages 1 and 2 should be filed within 72 hou.

'triment of Fleath and Mental Hygiene.

'rtant: If item 27 is marked other than """

or other traumatic event. 14during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jacquelyn F. Sherwood F. Morris IV Be William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 6665 Harbor Light Way, New Market, Md. Jacquelyn F. Sherwood/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 Removal from State 10/29/07 Alexandria, Va. Department of Important: I injury or oth Metropolitan Crem. Donation 5 Other Specify 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee 23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 20882 Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death **Viedical** a. Asphyxia and Blunt Force Injuries Immediate Cause (Final disease _xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 24 hours after death.

24 hours after death.

e Funeral Director: After this certificate has been signed by the attending physician and etelly filled in by the funeral director, page 2 should be detached for use as the burial - transit ician/Medical **AMENDED** UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth 2 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown þ يم Completed 24b. Were autopsy findings available 24a, Was an Records, prior to completion of cause of death? autopsy performed? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Nursing Home 5 Residence 6 V Other: Scene examiner? FR/Outpatient 3 Inpatient 2 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury FOUND: 28b. Time of Injury 27. Manner of Death Subject assaulted FOUND 1 Yes 2 ✔ No Natural Pending 0039 hrs Oct 26, 2007 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 6661 Harbor Light Way, New Market, MD Suicide (Specify) Townhouse / Rowhouse determined 4 V Homicide

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Carol Allan, MD 3 0 2007

30. Name and address of person who completed cause of death (Item 23a)

elec

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 26, 2007

completely

To the I within 2.

Medical

State

Registrar

29a. Certifier

29b. Signature and title of certifier

1 ol

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician:

3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

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within 24 hours a To the Funeral I State

cal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC MCDonald MD 7503 Surratts RD clinton, MD 20735

10/21/07

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, OCT 3 0 2007

29b. Signature and title of certifier

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:45 PM Guadalupe Beza Martinez October 26, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore 8. Date of Birth (Month Day, Dec 13, . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1949 ElººSalvador 1 XM 2 □ F 57 220-31-0789 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 XYes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iral", or items 23a or Examiner must be 6101 Glennoak Avenue 21214 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Salvadorian Specify: δ White Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pedro Beza Alvanez Rosa Martinez Aqueroa 2 19a. Informant's Name/Relationship (Type. Print)
Nancy Beza (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Glennoak Avenue, Baltimore MD 21214 Department of Health ar Important: If item 27 is any Injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) 4 □ Donation Stanislaus Cemetery 10/30/07 Dundalk, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End-stage heart disease unknown /Medical Due to (or as a sequence of): . Non-ischemic cardiomyopathy. Unknown Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injurated events. Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No 2 □ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Division or Vital Records, P.O. Box 68760 signed by the a certificate After this s after death.

It Director: After this of in by the funeral d within 24 hours a To the Funeral I

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

"natural",

Baltimore, Maryland 21215-0036

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 October, 26, 2007 impleted cause of death (Item 23a) (Type, Print)

1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M.D. Union Memorial Hospital, Baltimore, MD QUI ANZON, M.D. ( 32. Registrar's Signature

State Registrar

Medical

29a. Certifier

			For State Registrar		State of	f Marylar		partment of ertificate o			lental Hy	giene Reg. Ne.	007	7 36318	
	Physicia	an	1. Decedent's Name	(First, Middle, La	ist)						2. Date of De Month	aath Day	Yea	3. Time of Death	
	/Medic	al	PETER JO								OCTOBE	-	200		
	Examin	er	4a. Facility Name (If	24				4b. City, Town		tion of Death			County of D		
	Funeral	0	5. Social Security No.			7. Age (In yrs.	last birthda	ANNAPO ay) If Under 1 Yea	ar If Ur	nder 24 Hrs.	8. Date of Bi	rth		RUNDEL Birthplace (State or Foreigr Country)	1
	Director		315-40-8	132	1 <b>X</b> M 2□F	67	Yrs	Months Day	s Hou	urs Min.	(Month, Di		940 I	NDIANA	
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	ehov	5	10a. State	10b. County			ity, Town or							10d. Inside City Limits 1 ☐ Yes 2 XNo	
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	with a or		302 TOWE						, 21666			•	TED S'		
	Jeath The 23	Funerai	11. Marital Status	K DKTAF	12. Was Dece	edent Ever in U	J.S. 1	3. Was Decedent o			ecify Yes or N			merican Indian,	_
350	n 72 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f ehow edical Examinet must be notified at			ed 2. Married 4 □ Divorced	Armed Fo 1 XYes II Yes, Giv Year or Di	2 🗆 No		If Yes, specify Co			Rican, etc.)		Black, W Specify:	√hite, etc. ₩HITE	
5-0036	2 hou	Completed by		15. Decedent's E	ducation	1701	16a. De	cedent's Usual Occ	cupation			16b. Kin	d of Busine	ess/industry	
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89		edical			_ d										
ROX	death certific e ettending p id for use as t	Physician/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out			205				2	3d. Date of	delivery	
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	The law requires that the ste hes been signed by the page 2 should be detache	Ď	Part II. Other signifi	icant conditions	contributing to de	eath but not re	sulting in th	e underlying cause	given in F	Part 1.				te to the cause of death?	
0	w require been si should t	sted						·			10	Yes 2L	]No 3[		
Division of Vital Records,	e law hes b	Completed									24a. Wa		24b. Were prior deat	e autopsy findings available to completion of cause of	,
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حَ	rs effe	Certification;	- I Tomoldo		Dulidi	ing, etc. (Spec	<i>''y</i> /				City Of T	WII, State/			
	S To the Hospital or Attanding Physician: Owithin 24 hours efter death. To the Funerel Director: Atter this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)	2 Medical Exa	miner: On the b	asis of examin	ation and/o	eath occurred at the or investigation, in m	y opinion	, death occur	red at the time	, date and	place, and	due to the cause(s)	
	To the To the comp	Me	29b. Signature and	title of certifier	(			29c. Lice	ense num	ber		29d. Date	signed (N	fonth, Dey, Year)	
	RP		<b>)</b> /	nomo,	Walst	4 Mis	0.	Do	₹ <i>38</i>	67		10-	24.	07	
	12		29b. Signature and 30. Name and address THOMAS 31. Date filed (Monit	ess of person who	completed caus	se of death (Ite	m 23a) (Ty	pe, Print) Drive	Ster	rensu	ille.	MD	210	666	
5	Sta		31. Date filed (Moni	th, Day, Year)	32. R	Registratr's Sign	nature						·		
	Registr	ar		0612	5 ZUD/	Miller	ノグ	aparle							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygien & UU / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 16:44 P M MARIETTA R. MCFADDEN **OCTOBER** 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL EASTON TALBOT If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Months Days 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Months 1 ☐ M 2 🕱 F Director 70 MARCH 12, 1937 PENNSYLVANIA 166-28-2858 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d Inside City Limits r then "naturel", or Items 23a or 28a-f shorthe Medical Examiner must be notified at Funeral Director 1 Yes 2 Xio MARYLAND QUEEN ANNE'S OUEENSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 369 HEMSLEY DRIVE death 21658 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after □Yes 2 No 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No If Yes, Give Year or Dates: þ Specity. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Pages 1 and 2 should be filed w thrent of Health and Mental Hygien tant: If item 27 is marked other ti jury or other treumatic event, ib 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL CONTINO ပ္ ELIZABETH HENRY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL MCFADDEN/HUSBAND 369 HEMSLEY DRIVE, QUEENSTOWN, MARYLAND 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State OCTOBER 27 1 XBurial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ST. PETER & PAUL CEMETERY 2007 SPRINGFIELD, PENNSYLVANIA 21. Signatura of Juneral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY EMBOLUS /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 X No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy page certificate 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ▼ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation after death.

I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 5 29b. Signature and title of cer 29c. License number 10 29d. Date signed (Month, Day, Year)

Off 10

Maryland 21215-0036

Baltimore,

Box 68760.

P.O. P

Division of Vital Records.

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Signature

PATRICIA BOWYER, M.D.

OCT 2

31. Date filed (Month, Day, Year)

D0056076

115 SALLITT DRIVE, STEVENSVILLE, MARYLAND 21666

OCTOBER 24, 2007

#### **Physician** Charles L. Merwin, Jr. Oct. 26, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Days Months Hours 1 X M 2 □ F 578 44 1992 Director 95 June 30, 1912 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show Examiner must be notified at MD Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 9707 Old Georgetown Rd. #1525 20814 United States or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) International Elementary/Secondary (0-12) College (1-4or 5+) 5+ Economist Monetary Fund 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Lewis Merwin Estella Dora Meek ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grier Humphrey Merwin/Son Harrison St. Brookline, MA 02446 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State National Crematory 10/28/2007 Falls Church, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave., NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, Due to lor as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myocardial Infarction The law requires that the death certificate be executed Due to (or as a consequence of) physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Sparles Lewis merwin 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24a. Was an has le 2 er this certificate has eral director, page 2 autopsy perform 1∐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1 X Natural 2 ☐ Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

7:05A

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

4 Days

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No

Month

1 Yes 2 No

Ohio

Black, White, etc.

Specify:

White

157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) MK MD 0051268 Oct. 26, 2007 person with completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Bethesda, MD 20814 00101

State Registrar (Check only

30. Name and addres

29b. Signature and title of certifier

Nancy Lawless MD

OCT 2 9 2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:55 a_M **Physician** 2007 21, McCarty October William /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Rehab. and Nursing Ctr. Burtonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye June 24, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Year) 1929 5. Social Security Number Months Days **Funeral** 1 🕱 M 2 🗆 F Texas 78 056-22-6029 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 22. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 4 No Prince George's Director Adelphi Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20783 1733 Metzerott Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 XX ever Married 2 ☐ Married Specifyhite 1 ☐ Yes 2KKNo Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Religious Catholic Priest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Marie Weir William James McCarty 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9001 New Hampshire Avenue, Silver Spring, MD 20903 Jordan Baxter/Religious Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 30 1 XBurial 2 ☐ Cremation 3 X Removal from State St. Joseph Cemetery 4 □ Donation 5 □ Other (Specify) 2007 Fort Mitchell, AL 22 Name and Address of Facility ins Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Puneral Service License tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bads on each line. 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final Physician disease or condition resulting in death) Intracranial Hemorrhage /Medical Due to (or as a consequence of) Examiner Glioma Sequentially list conditions, if any, leading to immediate cause. Enter the design of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical The law requires that the death certificate 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death Ö detached 9 Unknown cate has been signed by page 2 should be detacl Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2,☐xNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? Yes 2 No 2 🗌 No 1∐ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: 4 Anursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 🛱 o 1 Inpatient 2 ER/Outpatient 3□ DOA ٩ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural Injury 5 ☐ Pending investigation To the Hospita. ... within 24 hours after death.
To the Funeral Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number and som

State Registrar IASNIEM

31. Date filed (Month, Day, Year)

OCT 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

2835 8 Registrar's Signature

State of Manyland / Department of Health and Mental Hygierre O O

	λΜ <b>ε</b> ιν	D#3	State of Maryland / Department of Health and Mic		Reg. No.	1 36322
	off adjoint	S.	XELI-D10/23/07, IL-M,I-XXX	2. Date of Dee	oth	3. Time of Death
	Physici /Medic	al		Oct. 24	, 2007	4:08am
	Examin	Aug al	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc			
		9.40	Bel Pre Nursing Home Silver Sp.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	ring  8. Date of Birti (Month, Day	Montgor	9. Birthplace (Stete or Foreign Country)
	Funeral Director		5.77-54-8138  Usual Residence of Decedent	Nov. 26	, Year) 5, 1943W	ashington, DC
			10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Be-f si	ctor	Maryland Prince Georges Beltsville, Maryland			tv Yes 2 □ No
	th with the Marylan 23e or 28e-f show ust be notified at	Funeral Director	10e. Street and Number         10f. Zip Code           4413 Romlon Street         20705		10g. Citizen of W	. A.
020	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or items 23e or 28e-f show ent, the Medical Examiner must be notified at	by Fune	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Forces?  1 □ Yes 2 ☑ No Specify:		Biack	- American Indian, s, White, etc. Black
21215-0020	ithin 72 h ie. ien "netu	To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)		16b. Kind of Bus	siness/Industry
2	fled w flygier her th	S	4 years Residence Manager  17. Father's Name (First, Middle, Last)  18. Mother's Name			a)
Maryland	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is merked other then other traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event.	Be c	Isaac L. Marshall Velma Lac			,
ary	should nd Me mark mark	Ţ	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rura</i> )	I Route Numbe	er, City or Town,	State, Zip Code)
	and 2.		Patricia D. Marshall -wife 4413 Romlon St., Beltsv	ille, N	Maryland	, 20705
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item 2 any Injury or other ance.		20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place)		Riverdal	City or Town, State e, Maryland
alti	mit. porta y inju	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	3831 (	Georgia .	Avenue, N. W.
œ	88 = 88		MD 278Latney's Funeral Hom	ne Wash:	ington,	D. C. 20011
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  a. A cute Myelos Leuke Due to (or as a consequence of):		rrest,	Approximate Interval Between Onset end Death
x 68760,	ifficate be executed g physician and as the burial-transit	/Medical Examiner	Due to (or as a consequence of):    A			
Box	eath cert attendin I for use	clan	Down Colon of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	23h Did	tohecco use con	tribute to the ceuse of death?
P.O.	es that the designed by the a	Physiclan/	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.			3 □ Probably 4 Unknown
Division of Vital Records,	s been sign	Completed by		24a. Wes	an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
R	nysician: The law his certificate has t il director, page 2 s	EO		10	Yes 2□No	1 ☐ Yes 2 ☐ No
/ita	clan: ertifice actor, (	Bec	25. Was case referred to medical examiner?			
of \	hysic this ce		1 ☐ Yes → No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: → Nursing Hor		dence 6 □Othe how injury occurr	
ono	Jing P. h. After funer	tlon	27. Manner of Death  1	200. 2 000.	,,,,,	
Divisio		ertifica	ZUACCIONI	28f. Location ( City or To	Street and Numb wn, State)	er or Rural Route Number,
_	To the Hospital or Attending Is within 24 hours efter death.  To the Funeral Director: After completely filled in by the funer	edical Certification: To	29a Certifier (Check only one)  Certifying Physician: To the best of my knowledge death congred at the firms date and place of the death occurred and manner stated.	and due to the ed at the time,	cause s, and ma date and place, a	nner as stated. and due to the cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier			i (Month, Day, Year)
A	7/		Survey 01487/6		10.2	5.07
		İ	30. Name end address of person who complet dicause of death (Item 23a) (Type, Print)	MD	20852	Section 2018 1 Comment (Comment of Comment o
	Sta	to	Suresh C. Gupta, M.D. 4701 Randolph Rd #203; Rockville  31. Date filed (Month, Day, Year)  32. Registrer's Signature	ב עודיו ני	20032	
	Regist		OCT 2 9 2007 Decree 15 Page 1			

4b. City, Town, or Location of Death

4c. County of Death

State of Maryland / Department of Health and Mental Hygienez 0.0736323 For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 Oct. 26, 3:00 P M John Wesley Paugh

Physician	
/Medical	
Examiner	

4a. Facility Name (If not institution, give street and number)

**Funera** 

Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at aprese.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	809 K St.			-	Mountai	n Lake P	ark		Garret	t
	5. Social Security Number 220–32–4324	6. Sex 7. Add 1 X M 2 ☐ F	ge (In yrs. last I	birthday) _ Yrs.	If Under 1 Year Months Days	il Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 10/2/19	th y, Year,	9. Bin	thplace (State or Foreign
			13	5 (10/2/1932 Maryland						
	Usual Residence of Decedent  10a. State 10b. County		100 City T		ation					10d Incide Circlinia
			10c. City, To							10d. Inside City Limits
	MD Gar		Mou	ntain La	ke Park				1X Yes 2 □ No	
Sire	10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?		
i	809 K St.		21550				USA			
	11. Marital Status	Ever in U.S.	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>			o- 14. Race - American Indian, Black, White, etc.				
Be Completed by Funeral Director	1 ☐ Never Married 2 📉 Marrie 3 ☐ Widowed 4 ☐ Divorced	[No	1 ☐ Yes 2 No Specify: Specify:					Specify:	White	
	15. Decedent' (Specify only highest	16	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
-	Elementary/Secondary (0-12)	5+)	Farmer					Farming		
1	17. Father's Name (First, Middle, L	Last)				18. Mother's Nar	me (First, Middle,	Maide	n Surname)	
	Murray Edwa	rd Paug	;h			Car	rie		I	laskell
	19a. Informant's Name/Relationsh	nip (Type, Print)	1:	9b. Mailin	g Address (Street	and Number or Ri	ural Route Numbe	er, City	or Town, State,	Zip Code)
	Agnes A. Paugh/	Wife	8	309 K	St., Mo	untain L	ake Park	, M	aryland	21550
	20a. Method of Disposition 1 X Burial 2 ☐ Cremation		ceme	tery, crem	sition (Name of natory or other place	. 1	Date		Oc. Location - City or Town, State	
	4 Donation 5 Other (Sp	Λ.	Deer		rk Cemetery 10/29/07 Deer Par					<u> </u>
	21. Signature of Funeral Service	Johnson D.			Name and Addre				Second S	St. 21550
-	23a. Part1. Enter the disease, or	complications that cause	d the death. D	o not ente	er the mode of dying	g, such as cardia			u,	Approximate
	shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.		,	•				Interval Between Onset and Death
	disease or condition resulting in death)	a	Cancer							One Month
		Due to (or a	s a consequenc	ce of):						
	Sequentially list conditions,	b		0.00						
	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury									
3	that initiated events resulting in death) Last	C. Due to for a		na af\;						
ì		Due to (or as	s a consequenc	<b>ж</b> ог).						
		d								
	IF FEMALE:	22a If use suteem								
by Physician/Medicai Examiner	23b. Was decedent pregnant in the past 12 months?  1								23d. Date of delivery  Month Day Year	
	Part II. Other significant conditio	ns contributing to death	but not resulting	g in the un	iderlying cause on	en in Part I.	23e. Did t	obacco	use contribute t	o the cause of death?
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Acute Pancreatitis (recent)  1 Yes 2 No 3									robably 4 Unknow
	24a. Was an 24b. Wer									utopsy findings availab
Complete				autopsy perform			psy ormed?	prior to completion of cause of death?		
5	25. Was case referred to medical			1 ☐ Yes 2 🔼 No					o 1 Yes 2 No	
	examiner?  1 Tes 2 No	Hospital:	iont office	26. Place of Death (Check only one)  ☐ EP/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify)						
	27. Manner of Death	1 ☐ Inpat	iury 28t	Outpatien	A Mursing Home 5 M Hesio			dence 6 ∐Other (Specify) how injury occurred		
Certification:	1 XNatural 5 Pending 2 Accident investig	ury 28b. Time of 28c. Injury at Work?  Injury M 1 ☐ Yes 2 ☐ N								
	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 289. Place of It	28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)				28l. Location (Street and Number or Rural Route Number, City or Town, State)			ural Route Number,
	29a Certifier 1 2 Certifyin									
	oney	and manner s	stated.	anwor my			uneu at the time,			
:	29b. Signature and title of certifier				29c. License number 29			29d. D	29d. Date signed (Month, Day, Year)	
	Bank	Abraul	MI	>		D27205			10/26/0	07
	30. Name and address of person	who completed cause of	death (Item 23	а) (Туре, І	Print)					

State

Registrar

Dr. Karl Schwaln, MD

2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

311 N. Fourth St., Oakland, Maryland

21550

Physician /Medical **Examiner** The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, physician the

Important: If item 27 any injury or other tr.

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner ed by the a detached for signed It þ Completed certificate has be rector, page 2 s Be Medical Certification: To nours after death.

neral Director: After this y filled in by the funeral d within 24 hours a

if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Sei 28re d, o  Due to (or se a consequence of):  Mental Retand	ands.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
	ontributing to death but not resulting in the und 5 taphy lococurs average.	, ,	23e. Did tobacc	o use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown					
			24a. Was an autopsy performed 1∐ Yes <b>2</b> €						
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 Tes 3 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)								
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	niner: On the best of my knowledge, death on iner: On the basis of examination and/or inversing and manner stated.								
29b. Signature and title of certifier		29c. License number	29d. I	9d. Date signed (Month. Day, Year)					

D25640

Clinton, Md.

October 19, 2007

State Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician:

7801 Old Branch Ave.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signatur

Khosrow Davachi,

OCT 3 0 2007

31. Date filed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 27 2007 8:20 William W. Pettway, Sr. October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 648 Ridge Road Rising Sun Ceci1 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under **Funeral** Hours Min 1 XM 2 ☐ F Months Days 216-38-7222 63 Director Nov. 17, 1943 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 648 Ridge Road 21911 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "ns any injury or other traumatic event the ince." Elementary/Secondary (0-12) College (1-4or 5+) 9 <u>Stationary Engineer</u> Linen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Pettway Ida Moreno ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Pettway/Wife 648 Ridge Road, Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-31-2007 Rising Sun, Maryland Brookview Cemetery 22. Name and Address of Facility
R. T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee S. Queen Street, Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine requires that the death certificate be executed burial-trans and Due to (or as a consequence of): physician Box 68760 Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9□Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1. Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an certificate has 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? ne Hospital or Attending Pin 24 hours after death.

Pe Funeral Director: After ti 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination any or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29c. License number 29d. Date agned (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) egistrar's Signature State 0 2007 OCT 3 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician**  $P^{M}$ October 26 2007 1748 Padmaben Patel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 2, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Indía 1932 156-94-6000 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at agnee. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director New Jersey Somerset Bridgewater 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 08807 12 Woodward Drive India Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2 💢 No Completed by 3 ☑ Widowed 4 ☐ Divorced Asian Indian 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shankarbhai Patel Kashiben Patel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Woodward Drive, Bridgewater, NJ 08807 Bhanu Patel/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date October 29 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Somerset Hills Crematory 2007 Basking Ridge, NJ Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 re of Funeral Service Licensee 21. Signat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTI **Physician** /Medical Due to (or as a consequence of) Examiner SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed CORONAR burial-trar Due to (or as a consequence of) physician VISEASE BLVUL Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ģ 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Be Completed by pe 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To After this Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed UNION ATRICIA 31. Date filed (Month, Day, Year) State 3 0 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene State Registra MEND#26perMF10/29/07, BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Tien Van Pham 12:13 p M October 2007 15 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 18 M 2 □ F Hours Country) Maryland Director 586-32-5673 75 November 13,1931 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery 01ney 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4020 Briars Road 20832 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 [**X**]
If Yes, Give
Year or Dates: 1 ☐ Never Married 25 Married 2 **X** No altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☒ No þ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than 's event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Chief of Army Signal Corps Vietnamese Military permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tai Van Pham ဥ Ngo Thi Le 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Huong Pham - Daughter 2437 Pimpernel Drive, Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 10/22/2007 Silver Spring, Maryland 21. Signature of Juneral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ncero /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and -trans Due to (or as a consequence of) physician at the buria -Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a detached f 9□Unknown 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1☐ Yes 2 No Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 1∐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 XInpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ac o completed cause of death (Item 23a) (Type, Print) 810 31. Date filed (Month gistrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 17:49 M **Physician** NOVEMBER 042007 REVEL PATRICIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ARUNDEL CENTER ANNAPOLIS ANNE MEDICA ARUNDER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08–30–1936 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funerai 1 ☐ M 2 🛣 F Months Maryland Yrs Director 220-32-2909 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location with the Maryland 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Deale Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20751 6116 Drum Point Road Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify: Baltimore, Maryland 21215-0036 'natural', or white þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 11 d 2 should be filed with and Mental Hygies 7 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernestine Virginia Lerov Francis Derouen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 Is
any injury or other trau 6116 Drum Point Road, Deale, MD 20751 John W. Revell, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dunkirk, MD So. Memorial Gardens 11-08-07 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony LAne, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INFECTION TRACT URINARY Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical the as attending p for use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a ld be detached f 9☐Unknown o. 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ULCERS DECUBITUS peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ARTERY SEASE ORONARY has e 2 performe 2 No 1∐ Yes this certificate DIABETES Division or Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier D 0 61776 NOVEMBER MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MARYLAND 2140 ANNAPOLIS, DEFENSE HIGHWAY, SUITE 400 BRIAN E. WOLF 116

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month; Day, Year)

32. Registrar's Signature

			ype or Print in E				-	_	
		For State Registrar	State of Marylan		partment of e <i>rtificate of</i>			ne . No. 2 1 1 7	
Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic	al	Evelena R	Stemple		1			31 200-	
Examin	er	4a. Facility Name (If not institution, give si			4b. City, Town,	or Location of Death		4c. County of Dea	
Funeral Director	2	5. Social Security Number 6. Sex		last birthda Yrs.	y) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, You 05/15/19	ea <i>r)   C</i> i	thplace (State or Foreign ountry) t Virginia
and ww		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or	Location				10d. Inside City Limits
a-f sho	ctor	WV Preston		Auroi	a				1 □Yes 2 □No
vith the	Director	10e. Street and Number			10f. Zip Code			. Citizen of What C	
leath v ns 23e must	Funeral	RT. 1 Box 28E Aur	ora 2. Was Decedent Ever in U	S. 1:	2670.			U.S.A.	erican Indian
rs after d ", or Iten caminer	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	.0.	If Yes, specify Cu 1 ☐ Yes 2 ☐ No	Hispenic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	te, etc. hite
2 hour	ted k	15. Decedent's Educ	ation		cedent's Usual Occi		16	b. Kind of Business	/Industry
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade Elementary/Secondary (0-12)  8	College (1-4or 5+)	life	ve kind of work don . DO NOT use retir Iomemaker	e during most of work ed)	ing	Self	
be filectal Hyg	Be C	17. Father's Name (First, Middle, Last)	-				e (First, Middle, Ma		
hould I d Men пагке патіс е	은	Alva Shrout, Sr  19a. Informant's Name/Relationship (Typ	o Print)	10h Ma	iling Addrago (Street	Helen	DeBerry	24 T Ot-1	7.0
and 2 s alth an 27 Is :		Richard Stemple	e. rmkj		Box 28			26705	ZIP Code)
ges 1 at of He If Item or other		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Re		Place of Dis cemetery, c	position (Name of rematory or other pi	ace)	Date 20	c. Location - City or	Town, State
it. Pa intmen intant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		rora	Cemetery	11/0	03/2007 A	Aurora, W	V
perm Depa Impo any i		Im Hulla	we DO		P.O. Box	ress of Facility Bro	wning Fur st Main S	neral Home Street Ki	e ngwood,WV2653
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Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	12	Faration				Onset and Death
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executed in and ial-transit	Exan	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):			-		
ficate be ex physician s the burial		<b>€</b> d.							
leath certific attending pl	/Ме	IF FEMALE:	c. If yes, outcome pf pregna	anov			<u>.</u>		
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death	B □Ectopic pregnan D □ Other (specify)	су		23d. Date of de Month	Plivery Day Year
that the		Part II. Other significant conditions conf	inbuting to death but not res	ulting in the	underlying cause g	iven in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
w requires that the d been signed by the should be detached	ed by	Tobacco use					1 ☐ Yes	2 □ No 3 P	robably 4 □Unknown
law re nas ber e 2 sho	Completed					*	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
							performe 1 Yes 2	d? death? No 1 ☐ Yes	
ysicla s certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2	ER/Outpat	ient 3 DOA	ther:	th (Check only one) ome 5 🗆 Residence	on 6 Other (Sp.	noife)
ng Ph fter thi	J:T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inj		28d. Describe how		ecity)
or Attending Physician: after death. Director: After this certifics in by the funeral director, i	icatic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At he	omo form	M 1[	]Yes 2 □ No	Oof Location (Chr.		
ital or A rs after or ral Direct led in by	Certification:	4 ☐ Homicide determined	building, etc. (Specia	(y)			City or Town, S	State)	lural Route Number,
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physic (Check only one) 4 Medical Examin	iclan: To the best of my kno er: On the basis of examina and manner stated.	wledge, de ation and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occur	and due to the caus rred at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
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		30. Name and address of person who cor	Inleted cause of death (Hor	n 23a\ /Tv-				11/1/260	1
	3	Andrew Foy, mp	Eglon Clinic	P.6.	Bex 8 Eg	100, WV	21716		
Sta Registr		31. Date filed (Month, Day, Year)  NOV - 2 2	32. Registrar's Signa	ature	A STANTED				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar			ertificate of l		R	leg. No. 4	2007	36330
۲	Physicia	an l	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic			chmidt		T		October		, 2007	3:30 A M
	Examin	er	4a. Facility Name (If not institution, give street	•			Location of Death	1		ounty of Deat	
- 1	F. Vernel	er .	4702 Hardwood ( 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthda	Mt. A		8. Date of Birth	1	Freder:	LCK nplace (State or Foreign
(h) Lagr	Funeral Director		521-06-4824		Yrs	Months Days	Hours Min.	Sept. 2	, Year)	Co.	ahoma
	land ow		10a. State 10b. County	10c. Ci	ty, Town or	Location					10d. Inside City Limits
	Mary I-f sh	ţ	Maryland Frederick		Mt	. Airy					1 ☐ Yes 2 No
	h the or 28s	Directo	10e. Street and Number			10f. Zip Code		1	I0g. Citize	en of What Co	untry?
	th wil		4702 Hardwood Cour	t		2	21771		U	nited	States
	r dea	Funeral		las Decedent Ever in Urmed Forces?	J.S. 1	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14	I. Race - Ame Black, White	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifled at	þ	If	∏Yes 2 ∏X No Yes, Give ear or Dates:		1 ☐ Yes 2 ☒ No	Specify:				hite
2	72 h 'natu dical	etec	15. Decedent's Education (Specify only highest grade con		16a. De	cedent's Usual Occup ive kind of work done o e. DO NOT use retired	ation during most of wor	king I	16b. Kind	of Business/	Industry
121	vithin the. than '	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)			1) -		17		
22	iled v Hygie ther t nt, th	ပ္ပ	17. Father's Name (First, Middle, Last)		AC	countant	18 Mother's Nan	ne (First, Middle,		nergy	
Maryland	d be f	Be c	William Clayton Mc	Brido				Ruth Can		,	
2	should Ind Men marke	은	19a. Informant's Name/Relationship (Type. P		19b. Ma	ailing Address (Street					Zip Code)
	and 2 sealth ar		Darwin D. Schmidt /	*		2 Hardwood		ít. Airy,			
ē	es 1 a of Hea f Item r othe		20a. Method of Disposition	20b.		sposition (Name of crematory or other place		Date		ation - City or	
E	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	vai iroini State		r Cremator	1 000	ober 29 2007	Fred	erick,	Maryland
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signify re of Puneral Service Licensee	*		22. Name and Addre	ss of Facility St	auffer E			
	700		23a. Part1. Enter the disease or complication shock, or heart failure. List only one ca	ns that caused the dea						, rial y	Approximate Interval Between
. =	Physician		Immediate Cause (Final	1-	1111000000	wolon C					Onset and Death
	/Medical		disease or condition resulting in death)	Due to lo as a conse	quence of):	WION C	THE CORP.				Months
B	Examiner		Sequentially list conditions b. —	9							
	₽ #	ner	if any, leading to immediate	Due to (or as a conse	quence of):						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
60,	rtificate be executed ng physician and as the burial-transit		Tooling in dodain, Edo	Due to (or as a conse	quence or):						
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ox 6	certifi iding se as	/Me	IF FEMALE: 23c. If	yes, outcome pf pregr	iancv				00	d Data of dol	ivon.
ă	The law requires that the death cer to has been signed by the attendinate has been signed by the attendinate 2 should be detached for use	Physician/N	in the past 12 months?	Live birth 2 Fet	al death	3 Ectopic pregnancy 5 Other (specify)	/		23	3d. Date of del Month	Day Year
o,	the c by the	ysi	9 Unknown	Unknown		_					
ري. ح	s that ned b	by PI	Part II. Other significant conditions contribu	ting to death but not re	sulting in th	e underlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
Records,	w requires been signe should be							1 □ Y	′es 2□	No 3□P	robably 4 □Unknown
ပ္ပ	law re	Completed						24a. Was a		24b. Were au	rtopsy findings available
		mo;						autop perfoi 1□ Yes	med? 2 No	death?	completion of cause of 2 □ No
Vita	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o			
<u> </u>	shysic this o	입	1 ☐ Yes 2 No Hospi	i ∐ inpatient 2 [		tient 3 DOA Oth	er: 4 🗆 Nursing F	lome 5XXResid	lence 6	□Other (Spe	cify)
U C	ding Ph h. After th funeral	on:	1⊠Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Tim Inju	ry Wor	k?	28d. Describe h	iow injury	occurred	
<u>s</u>	Attending Physician: r death. ector: After this certifics by the funeral director, i	cati	2 Accident investigation 3 Suicide 6 Could not be	a Blood of injury. At h	ama farm		Yes 2 □ No	DOL Lassins (C			
Division or	lor A after d Direct	Certification:	4 Homicide determined	Be. Place of injury - At he building, etc. (Spec	ify)	Street, lactory, office		City or Tou	n, State)	Number or Hi	ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)	On the basis of examir	owledge, d ation and/o	eath occurred at the ti	me, date and place	e, and due to the urred at the time,	cause(s) a	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
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7	2		30. Name and address of person who comple	eted cause of death (Ite	m 23a) (Tv	pe, Print)	2121		Viti	المعادل	1, 2001
1	4		ARIF HUSSQU	, 22 5	, 6	26848 6	St, B	alhmo	RS,	MD	21201
	Sta Registi		31. Date filed (Month, Day, Year) 0CT 3 0 2007	32. Pegistrar's Sign	ature	Sperle	6		,		•

		State Registrer	State of Marylar				ealth ar Death		Re	g. No.	007	36331
Physicia /Medic	an	Decedent's Name (First, Middle, Last)     Norman E. Spitz	er					(	Date of Death Month October	24	2007	3. Time of Death 13:45 M
Examin	er	4a. Facility Name (If not institution, give s Washington Advent	ist Hospital		Tak	Town, or  oma  r 1 Year			D-1 (0:4)	Mon	tgomer	у
Funeral Director		5 Social Security Number 6. Sex 100 100 100 100 100 100 100 100 100 10	M 20 E	90 Yrs.	Months		Hours	Min.	Date of Birth (Month, Day, 3/20/19	17 17	Wash	place (State or Foreigr ntry) ington, DC
within 72 nours atter death with the Maryland ene. Than "natural", or items 23a or 28a-f ehow tha Medical Examinar must be notified at	tor	10a. State 10b. County Maryland Prince Ge		ty, Town or Lo attsvil								10d. Inside City Limits 1X Yes 2 ☐ No
a or 28s	i Director	10e. Street and Number 3820 Oglethorpe St	reet			Code 20782	2		10	og. Citizer	of What Cou	intry?
in of Health and Mental Hygiene. If Itam 27 is marked other than "natural, or Items 23s or 28s-f show or other traumatic event, it a Medical Examinar must be notified at	by Funerai		12. Was Decedent Ever in U Armed Forces? 1 Mayes 2 No 194 If Yes, Give Year or Dates: 194	41-		dent of Hi ecify Cuba		in? (Specifi Puerto Ric	y Yes or No- can, etc.)	14.	Race - Amer Black, White	
iene. than "natur tra Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		life.	kind of we DO NOT t		during most ( f)	of working			of Business/li	urity Co.
and Mental Hygi s marked other umatic event. II	To Be C	17. Father's Name (First, Middle, Last) Otis Chapman					18. Mother	s Name (F	First, Middle, A			
27 is me r traume		19a. Informant's Name/Relationship (Ty.) Sandra Buchanan/Da			-				Route Number, Hyatts	-		ip Code) 20782
Department of Health a Important: if Itam 27 is any injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, crer rt Linc	natory or	other plac		Dat .0/29			tion - City or T	own, State Maryland
Departm Importa any inju		21. Signature of Funeral Service Licens	mille						Lincol , Brent			Home 20722
hysician and burial-transit the purial-transit	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of	quence of):  Style  quence of):  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Multiple  Mul	al ve ni	_ 1	nfa	wc	1 5	$\bigcirc$		Approximate Interval Between Onset and Death
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ate has b page 2 s	e Completed	25. Was case referred to medical								ned? Σ <mark>Ω</mark> No	death?	topsy findings available completion of cause of
h. After this funeral di	examiner?  1							of Death (Check only one)  rsing Home 5  Residence 6 Other (Specify)  28d. Describe how injury occurred  No  28f. Location (Street and Number or Rural Route Number)				
ours afte	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ca (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date									Town, State) he cause(s) and manner as stated.	
within 24 h To the Fur completely	Medi	29b. Signature and title of certifier	and manner stated.	D	2		se number	61			signed (Monti	0 N 0
10 / 1   Sta	ate	Van Mai, MD, 7600  31. Date filed (Month, Day, Year)		ue, Tal	,	Park	, MD 2	20912			en IX	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician October 24, 2007 Palencia Sanchez 1:20 p M Leonel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3506 Weller Road Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months XM 2□F 217-27-3067 47 Sept. 18, 1960 Guatemala Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 XNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3506 Weller Road 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White Specify: Guatemalan Baltimore, Maryland 21215-0036 1. Yes 2 □ No 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) School Bus Driver Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Justo Palencia Margarita Sanchez 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nidia Palencia/Wife 3506 Weller Road, Silver Spring, MD 20906 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 27, Gate of Heaven Oct. 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2007 Comptery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring MD 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) End-Stage Amyotrophic Lateral Sclerosis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 XNo 3 Probably 4 Unknown page 2 should k Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1∐ Yes 2x No Division or Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home SCResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred r Attending P er death. After Certification: Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atternation 24 hours (fer deal) To the Funeral Director 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D28079 October 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francine Higgs-Shipman, MD 1355 Piccard Drive, #100, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 2 9 2007 Registrar

n	1 - State Registrar 1. Decedent's Nam	ne (Firet Middle				and / Dep <i>Ce</i>	rtifica				2. Date o	Reg. No	00	0.7	3633
i	Rebec		e, Lasi)		SALT	ZMAN						er 25	^y , 20	00 ⁷ ar	12:41P.
r	4a. Facility Name (			et and nu					da da			M	Onto	jome	ery
	5. Social Security I  128-10-7  Usual Residence of	712 of Decedent		2 <b>X</b> F	90		Months	Days	If Under Hours	Min.	8. Date o	i Birth Jay, Year	917	9. Bii	rthplace (State or Foreig
Director	MD	MOntgo				City, Town or L Silver	Sprir					1			10d. Inside City Limit 1 ☐ Yes 2 📉 N
	10e. Street and Nu 10840 Ch						10f. Zi	p Code	2090	01		10g. Ci	tizen of t	What C	country?
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lo Be	17. Father's Name	ehuda	Pens							1	Bella		ninsl	ký	
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		Cremation 5 ☐ Other (S	Specify)	oval from		p. Place of Disp cemetery, cre t. Zior	n Ceme	etery	/ 0c	t.26	chins	7 Que	ens, orew	Nev Fur	or Town, State W York neral Home 20012
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State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCT. 2007 VALTINE 23, LOUISE TAYLOR 5:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Heartland Nursing Home Hyattsville P.G. If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Yrs. 50 Director N.C 577-78-7241 10-27-56 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturei", or Items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at D.C. N/A XXYes 2 No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 Fairmont St. N.W. #212 20009 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fed. Gov't Foreign Investment Spec 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be f nd Mentail Thomas Mitchell Lois A. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Lois A. Taylor/Mother 1400 Fairmont St. NW #212 20009 D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of I importent: if its any injury or o' once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/29/07 Brentwood, Md. * 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cem. 21. Signature of Funeral Service License. Hackett s Funeral Chapel, Inc. 814 Upshur Street, N.W. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Uneal HERNIATION. Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury BRAIN DISEASE certificate be executed use as the burial-transi TAST747 that initiated events and resulting in death) Last Due to (or as a consequence of): ding physician 68760 SZEAST Physician/Medicai Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 So 2 Fetal death 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death Day 5 Other (specify) o. 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Tes 2 No 3 Probably 4X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **X**No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: X Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the f 2 Accident Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö within 24 hours a

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completely filled 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D47867 Oct. 26, 2007 completed cause of death (Item 23a) (Type, Print) Zwaiga, Onley M.D. 4701 Randolph Rd. Rockville, Md. 20852 31. Date filed (Month, Day, Year) 0CT 2 9 2007 3 Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 100 Y 3) 200 The of Dea **Physician** DOY 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (# not institution, give street and number) **Examiner** Mon Year Birthplace (State or Foreign Country) MD 5. Social Security Number 6 Sex **Funeral** Days 1 □ M 2 😾 F 59 220-52-9441 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 0akland MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with 1 1 and Mental Hygiene. is marked other than "naturai", or Items 23a or? U.S.A. 18071 Garrett Highway 21550 . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify: 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stenographer Circuit Court 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maxine A. Glotfelty John Henry Skipper ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once, Garrett Highway, Oakland, MD Clifford D. Warnick/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/3/2007 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrett County MemorialGardnes 4 □ Donation 5 □ Other (Specify) Oakland, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Silvice Licen ee 21550 Md 32 S. Second Street, Oakland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YY +hmi disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknow Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 21 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Division or Vital Records, P.O. Box 68760, or Attending Physician: this nours after death.

nerai Director: After this y filled in by the funeral di

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes SZ No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Vear) 5 ☐ Pending investigation (Month, Day 1 ☐ Yes 2 ☐ No Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

,600 NORTH WOIFE STREET, BALTIMORE, MARYLAND 21787 Johns HOPKINS HOSPITAL Mock,

State Registrar

Medical Certification: To

31. Date filed (Month, Day, Year)

within 24 hours a

To the Funeral I

completely filled To the Hospital

As Facility Name (if not institution, give street and number)   48.17 A. Mussetter Road   1.3 msville   48.17 A. Mussetter Road   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms birminal   1.4 ms		1 - For State Registrar			artment of F rtificate of		, ,	eg. No. <b>?</b>	M7 3633
4a. Facility Name (I not institution, give street and number) 48.17 A. Mussetter Road  5. Social Social Security Number 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16.0-56-4295 16			·				2. Date of Dear Month October	26, 20	3. Time of Death 12:14P
160-56-4295   18 M 2 F   48 Yr.   Months   Days   Hours   Min.   O(Month, Days, Year) 959   Peminsylvania				)			1	}	
10a. State   10b. County   10d. Inside City Lit   1   1   1   1   1   1   1   1   1			. Sex 7. A				8. Date of Birth (Month, Day Oct 23	Year) 959	9. Birthplace (State or Forei Pennsylvania
1.1 Married Status	tor	10a. State 10b. County	ck						10d. Inside City Limi 1 ∐Yes 2☑N
11. Martinal Status   12. Wise Deposition if their in U.S.   12. Wise Deposition if their in U.S.   13. West Devoted and Distance   12. West Deposition in the interest   12. West Deposition in the interest   12. West Deposition in the interest   12. West Deposition in the interest   12. West Deposition in the interest   12. West Deposition in the interest   13. West Devoted and Deposition in the interest   14. Raper American Indian, Black, Wisin, and   12. West Deposition in the interest   13. West Deposition in the interest   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Raper American Indian, Black, Wisin, and   14. Rap	Direc	10e. Street and Number			10f. Zip Code		1	-	ŕ
16. Decededrix Extraction   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix Studies   16. Decededrix S		11. Marital Status  1 ☐ Never Married 2 Married	12. Was Deceden Armed Forces 1 Yes 2 K	i? ] No	Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - American Indian, ick, White, etc.
Temperate Name (First, Middle, Markers Surname)   Temperate Name (First, Middle, Markers Surname)			grade completed)	(Give	e kind of work done DO NOT use retired	oation during most of work d)	ing		_ ′
Kimberly K. Walls (wife)   4817 A. Mussetter Road Ijamsville, Maryland 2175	Be	17. Father's Name (First, Middle, La	•					Maiden Surna	me)
Support   Companies   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color (Specify)   Color		Kimberly K. Wall		481	7 A. Musso	etter Roa	d Ijamsv	ille,	Maryland 21754
The part   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Care   Car		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	e Stauffer	Crematory or other place Cremator	y Oct.			•
Shock, or he's failure. List—if one cause in each recommendate cause (Final disease or condition recolding in death)  Bue to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a conseque		Yacqueline	y tall	etter !	1621 Opos	sumtown P	ike Fred	lerick,	Maryland 2170
Sequentially list conditions.    Tight Leading It shows a sequence of the properties of the part in the past 12 months?   Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of):		Immediate Cause (Final disease or condition	_a. Meta	static.	. \	0			Approximate Interval Between Onset and Death
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1   Yes   2   No   3   Probably   4   Unknown of cause death?  25. Was case referred to medical examiner?  1   Yes   2   No   3   Probably   4   Unknown of cause death?  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury   28b. Time of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North of Injury at North						7			
24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Unkn    24a. Was an autopsy performed? 1   Yes 2   No 1   Probably 4   Unkn    25. Was case referred to medical examiner? 1   Yes 2   No 1   Probably 4   Unkn    25. Was case referred to medical examiner? 1   Yes 2   No 1   Probably 4   Unkn    26. Place of Death (Check only one)    27. Manner of Death   1   Inpatient 2   ER/Outpatient 3   DOA    28a. Date of Injury   28b. Time of Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Injury at Work?   No   28c. Inj	l e	Sequentially list conditions, if any, leading to an income cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			3			
25. Was case referred to medical examiner?  1	l e	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c	s a consequence of):  te pf pregnancy 2 □ Fetal death 3		y			,
25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c	s a consequence of):  the pf pregnancy 2  Fetal death 3 at time of death 5	Other (specify)			bacco use cor	onth Day Year stribute to the cause of death?
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c	s a consequence of):  the pf pregnancy 2  Fetal death 3 at time of death 5	Other (specify)		1 TY	bacco use cor es 2 No	onth Day Year  attribute to the cause of death?  3 Probably 4 Unknow  Were autopsy findings availat prior to completion of cause of death?
	o Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	c	s a consequence of):  te pf pregnancy 2 ☐ Fetal death 3 at time of death 5  but not resulting in the of	☐ Other (specify)	ven in Part I.  26. Place of Deat	1  Yes	bacco use cor es 2 No in 24b. sy med? 2 No	onth Day Year  stribute to the cause of death?  3 Probably 4 Unknow  Were autopsy findings availat prior to completion of cause of death?  1 Yes 2 No
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State Registrar

29b. Signature and title of cert

30. Name and address of person who completed Elhamy ES Kander, 31. Date filed (Month, Day, Year)

OCT 3 0 2007

o completed cause of death (Item 23a) (Type, Print)

Index, MD 501 W 7th Street Frederick MD 21701

32. registrar's Signature

2007 Brewn & Special

DHMH 17 Rev 1/2001

29c. License number

D 48184

29d. Date signed (Month, Day, Year)

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Philmore Wise October 26, 2007 Ам 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Health Care Center Hyattsville Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 24, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2 ☐ F 81 Director 218-16-9030 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at MD Prince Georges Brentwood 1 Yes 2 No Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4529 38th St. 20722 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) 3 College (1-4or 5+) Mail Clerk Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othe any nijury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philmore D. Wise Sr. Mary Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imogene Wise/ Wife 4529 38th St. Brentwood, MD 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 10/31/2007 Cheltenham, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Johnson & Jenkins Funeral Home Del 716 Kennedy St. NW, Washington, DC 23a. Part1. Enter the disease, or on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Senile Dementia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed physicien ar Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension been signated 1 Yes 2 No 3 Probably 4 Unknown ted Complet 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has page certificate 2 🗆 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 XNo 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058290 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Suresh Muttath 5711 Sarvis Ave, Suite #200, Riverdale, MD 20737

State Registrar

Division of Vital Records. P.O. Box 68760

31. Date filed (Month, Day, Year) 3 0 2007

For State Registra

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Adrian WEBBER 11:31 A ^M October 26, 2007 County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days New York 1 □ M 2 □ X F 70 060-30-5319 <u>March 4, 1937</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2 No Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20854 11107 South Glen Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation National Institutes of (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Health** Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Bernstein Samuel Steier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11107 South Glen Road, Potomac, MD Arthur Webber, Husband 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/28/107 Judean Memorial Gardens Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fundral Service Licensee 254 Carroll St., NW, Washington, DC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final aspiration neumonia disease or condition resulting in death) Conjugate the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the se Due to (or as a consequence of) Due to (or as a consequence of): gnancy 23d. Date of delivery etal death 3 Ectopic pregnancy Year Month Day 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

Department of Health a Important: If Item 27 is any injury or other trains

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

marked other than "natu matic event, the Medical

Maryland

Baltimore,

Box

Vital

0

Division

Director

Completed by Funeral

Be

Physician/Medical

Completed by

Be

Certification: To

Medical

State

Registrar

	u
IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1  Yes 2  No	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

nan carer cascinamatosi

Hospital:

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? Yes No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25.	Was c examir		referred	to	medica	
	1 □ Ye	es	217 No			

Manner of Death Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28a. Date of Injury (Month, Day Year)

1 Inpatient

2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of pertifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

86000ld Ourstere Rd. JEM.O. 32 Registrar's Signature 31. Date filed (Month, Day, Year)

OCT 2 9 2007

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After i completely filled in by the funeral

			. For	State of M	aryland /	Depa	artment of H	ealth and	d Mental Hy	giene	
		,	1 - State Registrar		-	-	tificate of L			Reg. N2 0 0 7	1 36339
	Physici	an l	1. Decedent's Name (First, Middle,						2. Date of De		3. Time of Death
	/Medic		Kathryn	Kleckner		hit			Novembe	er 2 200	07   9:15 A ^M
	Examin	ier	4a. Facility Name (If not institution,	-		i	4b. City, Town, or			4c. County of D	
	Euroval		5. Social Security Number		enter ge (In yrs. last b	birthday)	Prince If Under 1 Year	If Under 24 H	Irs. 8. Date of Bit	rth 9.	
	Funeral Director		191-32-0002	1□M 2ሺF	94	Yrs.	Months Days	Hours M	in. (Month, Da June	17 1913 Pe	Birthplace (State or Foreign Country) ennsylvania
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	aryla shov	៦									10d. tnside City Limits 1 ☐ Yes 2 ☼No
	286-1	rect	MD Calve	rt	Hun	ting	town			10g. Citizen of What	
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	deatl	Funeral Director	11. Maritat Status	12. Was Decedent Armed Forces	Ever in U.S.	13.			(Specify Yes or No Jerto Rican, etc.)		merican Indian, /hite, etc.
0	or It	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes 2 🔀 If Yes, Give		1	I □ Yes 2 🗓 No	Specify:	10110 1110411, 010.)	Specify:	
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<u>ה</u>	in 72 n "ne	plete	(Specify only highest	grade completed)		(Give	kind of work done of NOT use retired	du <i>ring m</i> ost of t	working	16b. Kind of Busine	ss/industry
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<u> </u>	d oth	Be (	17. Father's Name (First, Middle, La	ist)				18. Mother's N	Name (First, Middle	, Maiden Sumame)	
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ກ <u>ົ</u>	1 and Healt tem 2		Ramona W. Scot	it, daugnte.	20b. Place	of Dispo	sition (Name of		ntingtowr Date	n, MD 206.	
2	ages ant of nt: If it		1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				tan Crema	'	1 03-07	Alexandr	
panimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By the man 21st marked other then "neturelt, or thems 23a or 28e-f show any injury or other traumatic event, the Mealical Examinet must be notified at once.		21 Signature of Funeral Service Li		Mecro					neral Home	
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			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cause nly one cause on each !	d the death. Do	o not ent	er the mode of dying	g, such as card	diac or respiratory a	arrest,	Approximate Interval Between
, ,	Physician		Immediate Cause (Final disease or condition	Car	diac.	F	Frrhut	damic.			Onset and Death
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2	after Dire din b	erti	4 ☐ Homicide determin	buitding, e	tc. (Specify)		oot, tudiory, office		City or To	wп, State)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death, within 24 hours after death.  To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2	calC	29a. Certifier 1 Certifying (Check only 2 Medicat E	Physicien: To the best	of my knowled	lge, death	occurred at the tim	ne, date and pla	ace, and due to the	cause(s) and manne	r as stated.
	the H in 24 the Fu ipletei	ledical	oney	xeminer: On the basis of and manner si	a examination a tated.	and/or in			ccurred at the time,		
	To COU	Σ	29b. Signature and title of certifier	~ c 6	٠		29c. License	number	53	29d. Date signed (M	
			- Congress	( )			J U	>00)	//	11-2-	2001
	7		30. Name and address of person w	tho completed cause of	death (Item 23a	a) (Type,	Print) GVA	10 .0	2 5111	2ANA	N 907M
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	Registr	-	MAT 3 700	Jan Jan	rar's Signature	ional.	3				

				For State Registrar	State	of Marylar		artment of H		nd Mental Hy	giene Reg. No.		36340
		Physici		1. Decedent's Name (First, M.						2. Date of D Month Octob	Day	Year 2007	3. Time of Death 10:25 AM
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		Funeral		Manor Care Ro 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Baltim If Under 1 Year	If Under 2	4 Hrs. 8. Date of Bi	rth	Baltimo:	re place (State or Foreign intry)
	Ų.	Director		199-14-5186	1 M 2 □ F	80	Yrs.	Months Days	Hours	Nov 20			isylvania
		ehow		Usual Residence of Decedent 10a. State 10b. Cou		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
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411	920	or ite	þ	1 Never Married 2 🗓 1	Married 1 □XYes	Forces? s 2 □ No Bive Dates: 「45		lf Yes, specify Cuba 1 ☐ Yes 2 🎇 No	Specify:	Puerto Hican, etc.)		Black, White, Specify: wh:	
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^	ary	should and Men s marks	-	19a. Informant's Name/Relat	ionship (Type, Print)		19b. Maili	ng Address (Street		r or Rural Route Num	ber, City or	Town, State, Zi	p Code)
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0,31,0	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; any injury or other traumatic event, I'm Medical Exa once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremati 4 ☑ Donation 5 ☐ Other			cemetery, cre	matory or other place	ce)	-	200. 200	outlon only or .	own, oldio
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year BROGDON NOVEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) 1–22–1970 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year I If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □XM 2 □ F 218-74-8871 Director 37 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural" or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Baltimore Md. NA Director 10f. Zip Code 2.1216 10e. Street and Number 10g. Citizen of What Country? 2407 Arunah Avenue USA Funeral death y Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. I other than "natural", or Ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be is marked Cecelia Edward Brogdon, Sr. James Stevenson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Cecelia Stevenson Mother 2407 Arunah Avenue, Baltimore, Md. other 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Pages 1 Department of H Important: If ite any Injury or ot once. 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State
4 Donation 5 ☐ Other (Specify) 11-16-07 Randallstown, Md. King Mem. Pk. 21. Signature f Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Port1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm-plate Cause (Final **Physician** CARDIOPULMONARY dise e condition resultin n death) 50 MINS /Medical Due to (or as a consequence of) Examiner CEMIFICATION APPRINCED BY MEDICAL EXAMINE TOTAL BODY SURFACE WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner?
1 ▼Yes 2□ No Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient Other: P 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation latient litsult on fine 12009 after death.

Director: After in by the further (1/1/07 1 ☐ Yes 2 1 1 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide ac of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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21216 filled in by 4 Homicide

Ö <u>م</u> Division or Vital Records, I or Attending Fafter death. Hospital within 24 hours a

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

2007

ddress of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AN

At home

and manner stated.

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #10c,e&f Per FH G873 11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lula McDaniel Bates november 5,200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Haure If Under 1 Year Numina Track Home Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. Months 1 ☐ M 2 🕏 F Yrs Director 250-50-6255 Carolina Dec. 8. 1911 S. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location

Hyattsville 10a. State 10b. County 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Ex-miner must be notified at Laure1 Maryland Prince George Director 1 ☐ Yes 21 No 10f. Zip Code 20782 10e. Street and Number 13501 Bell Chase Blvd 10g. Citizen of What Country? 20707 4914 Avondale unit #211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Black 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th grade College (1-4or 5+) Cleaners Presser 18. Mother's Name *(First, Middle, Maiden Surname)* Ophelia Davenport 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Robert McDaniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13501 Bell Chase Blvd... of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type. Print) 20707 Shirley Dean Bates Renrick Unit#211 Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Belair Memorial Gardens permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Co., Md 22. Name and Address of Facility Chatman-Harris FuneralHome 21. Signature of Funeral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 usis seast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, illure. List only one cause on each line. Approximate Interval Between Onset and Death Part Enter the mediate Cause Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 100 death? 1 ☐ Yes Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 0 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation Division Injury 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a **To the Funeral I**completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Hong

31. Date filed (Month, Day, Year)

NOV 1 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hougs A. Sour

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U I Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day BAGLEY 54AM **Physician** November 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1809 Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Street 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months 50 Yrs. Director Q15-70-4036 SEPTEMBER 21, 1957 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10h County 10a State 10d, Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Seyes 2 □ No BALTIMORE NIA Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1809 STREET 11.S.A. VINE "natural", or Iteme 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. t 1. Marital Status 1 

Never Married 2 

Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) BALTIMORE CITY TEACHER'S AIDE 2 YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental F BAGLEY O'NEAL JESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWANDA LITTLE (DAUGHTER) 1528 W. FAYETTE ST, APT. B, BALTIMORE, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State MT. ZION CEMETERY 11-17-2007 LANSDOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2/40 North Fulton Avenue Baltimore 21. Signature of Funeral Service Licensee Joseph H. Brown, In Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** acrest /Medical Due to (or as a consequence of): Examiner heart tacture ongestive S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of): as the burial-transit certificate be executed Due to (or a a onsequence of): signed by the ettending physicien I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
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To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25€No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge ideath occurred at the time, date and clace and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29s Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/12/07 IMICOUR MD D003804 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) NOV 1 4 2007





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	1 V Natural	5 Pending	(Month, Day,Y	(ear)			1 Yes 2	No					
Nivision I or Attend after death. Director: d in by the t	2 Accident 3 Suicide	Investigation  Could not be	28e Place of In	ijury - At ho	ome, farm, stre	et, factory, o	office building,	etc. 28	Sf. Location (St		lumber or Rur	al Route Num	nber, City
Div Div Div Tal D Hed i	3 Suicide 4 Homicide	determined	(Specify)						or Town, St	ate)			
2-2-7		ertifying Physicia	n: To the best of m	y knowled	e, death occu	rred at the ti	me, date and	place, and du	e to the cause	(s) and ma	anner as state	d.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			on the basis of examind manner stated.	mination a	nd/or investiga	tion, in my o	pinion, death	occurred at th	ne time, date a	nd place, a	and due to the	cause(s)	
To with To con	29b. Signature and tit		Ind manner stated.			29c. t	License numb	er		29d. Date	signed (Mon	th, Day, Year)	
		1.11	1/4	/			O.C.M.E.			Octobe	r 28, 2007		
110	30. Name and addres	s of person who co	mpleted cause of o	leath (Item	23a)								
1017	Jack Titus ME	•	hief Medical E		,	nn Street,	, Baltimore	, MD 2120	01				
State			32 Registra	r's Signat	re A	AP B		-	-				
Registra	110	V 1 4 200	Kilasu4	لکر من	- FIDE	25							
DHMH 17 Rev 1/2001			-		ORIGINA	L			٥	CME			

O7-08425 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary Rachael Brown State of Maryland / Department of Health and Mental Hygiene

Continue of Death

2007 36345

		-	- For State legistrar				Cert	ificate o	of L	)eatn_			10		Reg. No.		3	. Time of Death
	. Physicia		1. Decedent's N	ame (First, Midd	ile,Last)									Date of De Month		Year		1756 hrs
`	Examir		MARA I	RACHEAL	BROWN	N .								Month October			I Decili	
			4a. Facility Nan	e (if not instituti	on, give str	eet and nur	nber)		4b.	City, Tow	n, or Lo	cation of	Death		1	c. County of		
				Maryland H					(	Clinton					1	Prince G	_	
			5. Social Secur		6. Sex		7. Age (In yrs. la	st birthday)	┪	If Under 1	Year	If Under	24Hrs.	8. Date of E	Birth(MN	I/DD/YYYY)	g, Birth Foreign	place (State or
	Funeral								_ [	Months	Days	Hours	Min.	10/13	/106		Cour	ntry) MD
	Director	- [	220 72	9385	1M	2 X F		38 Y	rs.					10/13	/ 150	) )		132
		ı	Usual Residen	e of Decedent														10d. Inside City Limits
	any		10a. State	10b. County	/		10c. City,	Town or Loc	ation	n								1 Yes 2 X No
		. 1	MD	PRING	TE GE	ORGES	UPI	PER MA	RL.	BORO								
	ylan -f st	흱	10e. Street and		011				-1	10f. Zip C	ode				10g. C	itizen of Wh	at Count	ry?
-	ath with the Maryland items 23a or 28a-f show any ist be notified at once.	Director			an no				- [	20	<b>)</b> 772	•			UN	NITED	STAT	TES
2	the sa or		6601 D	OWERHOUS				- T.o.i					in2 / Sne	ecify Yes or				an Indian, Black,
-	with ns 2.	ia	11. Marital Sta		1	<ol><li>Was Dec Armed F</li></ol>	cedent Ever in U	.S. 13. V	was f Yes	s, specify	Cuban,	Mexican,	Puerto I	Rican, etc.)		White		-
	death or item must b	Funeral	1 X Never N		Married	Yes	2 X No		_	-	=					Specify:	BLA	CX
	her de		3 Widowe	ed 4 🔲 🗅	Divorced If	Yes, Give Ye	ar			Yes 2					1465	. Kind of Bu		
	5-0036  ed within 72 hours after death with the Maryland stygiene doubter than "natural", or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	by	15. Deceden	's Education (Sp	pecify only	highest gra	de completed)	16a. Deced	dent's	s Usual O	ccupati	on (Give l	kind of w use retir	rork done red)	100	. King of bu	15111635/11	ladstry
	"nat	Completed	Elementary	Secondary (0-12	2)	College (	1-4 or 5+)	during	THOS	St OI WORK	ng mo.			,				
9	15-0036 filed within 72 Hygiene. d other than	ple		TH				но	ME	MAKE:	R					NONI		
3	with with giene	E		ame (First, Midd	lle Last)				_		1	8. Mother	's Name	(First, Midd	e, Maid	en Surname	e)	
	- Hys H - 1	ပ	l.								- 1	VAI	ERI	E MILI	ER			
	2121 ould be fil Mental I marked ic event,	m		C. BRO		o Print )		19b. Ma	iling	Address	(Stree	t and Nun	nber or F	Rural Route	Number,	City or Tov	vn, State	, Zip Code)
(	3, MD 21215-0036 and 2 should be filed within 72 hours after featht and Mental Hygiene, item 27 is marked other than "natural", or traumatic event, the Medical Examiner: traumatic event, the Medical Examiner:	ြို					•			ONNE				STRICT				
- 1	MD d 2 sho dth and m 27 is aumati			E MILLE	R / M	OTHER	Look	Place of Dis	nosi	ition (Name	بنب e of cer	netery.		Date	20	c. Location	- City or	Town, State
	Heal		20a. Method	of Disposition 2 Cremat	tion 2	Demoval	from State	crematory o	r oth	ner place)			ŀ					
	OF ges it of I: If		1 X Burial			Removai	ME	TROPOI	.77	TAN C	REM	ATORY	11	/15/20	007	ALEX	ANDR	IA, VA
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med injury or other traumatic event, the Med		4 Donati	on 5 Other	Specify:	96 4	1111	2	2, N	lame and	Address	of Facilit	YE'D A	T HOM!	7 OF	MARY	T.AND	, INC.
	Sal ermi Separ mpo mjur		$\cup \setminus \setminus \cup$	VYV	3 (	עטו	,		1. 1	3 U S C	بالشتلة	GKA.T	ROA	D SI	$_{ m JITL}$	AND, I	MD/Z	0746
		_	1	. I /	CULS	nations that	caused the deat	h. Do not en	ter th	he mode o	f dying,	such as	cardiac o	or respiratory	arrest,	shock, or h	eart	Approximate Interval Between Onset and
	`ysician		23a Wart I. E.	ist only one cau														Death
	ledica			ause (Final dise	ase a.	Nortri	ptyline a	nd tram	adc	ol into	OXIC	ation	_		_	_		+
	⊏xamine	1	or condition	esulting in death	n) D	ue to (or as	a consequence	of):										
			Sequentially	list conditions,	b				_		_		_					
		<u>ē</u>	if any, leading	g to immediate		ue to (or as	a consequence	of):										
		Ē	(Disease or	r Underlying Cau njury that initiate	od 0			of):	_									
	_14	Examiner	events resul	ing in death) La		oue to (or a	s a consequence	: 01).										
	cuted and transit				d								13					
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	760, ficate be executed g physician and	Physician/Medical	IF FEMALE:		_		s, outcome of pr									23d. Date Month		Day Year
	87(string plane)	2	23b. Was de past 12	cedent pregnant	in the		e birth	2		etal death	3	Ector	oic pregr	nancy		I MOTILITY		bay .cu.
	Centie	2 2	past 12			-	egnant at time of	death 5	0	ther (Spe	cify)				_	Ì		
	Box 68 e death certif the attending		1 Yes			3011	known							1 222	Did tobs	2000 USA 00	ntribute t	to the cause of death?
	the	בַּן בַּ		r significant co	nditions	contributin	g to death but no	t resulting in	the	underlying	g cause	given in	Part I.					obably 4 Vunknown
	r that	2	5											-   ¹ L	Yes			
	S, puires	, page 2 should be	<u> </u>											24a.	Was an		b. Were	autopsy findings available completion of cause of
	v req	Suous	<u> </u>											- [	autopsy		death'	?
	e lav	2 g												1 🗸	Yes 2	No	1 🗸	Yes 2 No
	Files	E C		se referred to me	edical T			10.6			26.Pla	ce of Dea	th (Ched	k only one)				
	tal cian	ecto	examine	er?	F	lospital:	Inpatient 2	✓ ER/Outp	atier	nt 3	DOA	Other ₄	Nur	sing Home	5 R	esidence	6 Oti	her:
	<b>7</b> is a sile	티	1 V Y		)	28a D	ate of Injury	28b. Tin			28c. lr	jury at W	ork?	28d. Des	cribe ho	ow injury occ	curred	
	After 1	uner	27. Manner			(N	onth, Day,Year)				1	Yes 2	X No	unk				
	sion strend death.	the 1	2 Acc	ural 5	Pending Investigati	ion Fnd	10/29/200	7 Fnd	5 <b>:</b> 3	18 pm		_		28f Loc	ation (St	reet and Nu	ımber or	Rural Route Number, City
	r Att	n by	3 Sui	5.0	Could not	28e l	Place of Injury - /	At home, fam	n, str	reet, factor	у, опіс	e building	, etc.	Or T	own Sta	ate)		MD
	Division of Vital Records, P.O. spinal or Attending Physician: The law requires that the hours after death.  Ineral Director: After this certificate has been signed by the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	ed		minido	determine	d (Spe		House										Upper Marlboro
	ospi hou				ing Physic	ian: To the	best of my know	vledge, death	000	curred at th	ne time,	date and	place, a	and due to th	e cause	(s) and mar	nner as s	stated.
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finieral Director: After this certificate has been signed by the attending physician and To the Finieral Director: After this certificate has been signed by the attending physician and	plete	(Check only one)  29b. Signa	2 Medica	I Examine	r:On the ba	isis of examination	on and/or inv	estig	gation, in n	ny opin	ion, death	occurre	ed at the time	e, date a	ina piasej e		
	To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To the To	com	9 000			and mann	ner stated.		_			ense numb				29d. Date:	signed (	Month, Day, Year)
•		3	29b. Signa	ture and title of o	//					1	0	C.M.E.				October	r 30, 20	007
1	-		1	milis	vithal	mn					<u>J.</u>	J.,,,,,_,						
			30. Name	and agedress of p	erson who	completed	cause of death	(Item 23a)							.04			
	0			ela E. Southa			ant Medical B		1	111 Pen	in Str	eet, Bal	timore	e, MD 212	:01			
		<u>و</u> .		ed (Month, Day,	Year)		Registrar's Sig	gnature						OCME				
	Par	Sta gistr		NOV 1	4 200		Rodine .	12 1	125	skis.								

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			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		THERESA MARGARET BEYER				NOV 12, 2	007	0630 A M
3	Examin	er	4a. Facility Name (If not institution, give street and numb		4b. City, Town, or	Location of Death	- V	4c. County of Dea	
~	Funeral		GENES IS ELDERCARE HAMMONDS LA 5. Social Security Number 6. Sex 7.	NE Age (In yrs. last birth		If Under 24 Hrs.	8. Date of Birth	ANNE ARU	thplace (State or Foreign
	Director		220.14.6002 1 M 2 F	83 Y	rs. Months Days	Hours Min.	(Month, Day, Y		ountry) MD
	pur w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Maryla f sho	ō		PDCOKLY	(A)				1 □Yes 2 □ No
	r 28a-	Director	MD ANNE ARUNDEL  10e. Street and Number	BROOKLY	10f. Zip Code		10g	. Citizen of What Co	ountry?
	th wit		613 HAMMONDS LANE		21225			USA	
	er dea	Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2	ent Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
5	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2 <b>XX</b> No	Specify:		Specify:	HITE
2-003p	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at		15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Occupa (Give kind of work done o	ation	ing 16	b. Kind of Business	
Z	within 7 iene. than "r	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	life. DO NOT use retired,	)	ang		
V	iled w Hygier ther th		12 17. Father's Name (First, Middle, Last)	HC	ME MAKER	18 Mother's Name	e (First, Middle, Ma	OWN HOME	
and	ld be f ental I ked ol c eve	To Be	LOUIS BAKER			APALONIA		idon damamo)	
a	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if Health and Mental Hygiene if the 72 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	F	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street a			City or Town, State,	Zip Code)
_	and 2 lealth a m 27 is		MARY ELLEN JOHNS		02 JENNINGS RE				
w	00		20a. Method of Disposition  ★★ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	cometer	Disposition (Name of v, crematory or other place	e)	Date 20	c. Location - City or	Town, State
	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	MD WATIO	NAL CEMETERY  22. Name and Addres		4.2007	LAUREL, MD	
Dall	permit. Departri Importa any Inju		2 Cuapry Ct	01148	FINK FUNERAL 426 CRAIN HWY	HOME, P.A.	7NIF NO 21	ns1	
			23a. Part . Enter the disease, or complications that cau shock, or heart failure. List only one cause on each		<del></del>				Approximate Interval Between
	Physician		Immediate suse (Final disease or condition	Mosis					Onset and Death
,	/Medical Examiner		resulting in death)  Due to (or	as a consequence o	f):				
š		ē	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence o	f):				
19	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
ک ر	cate be executed oblysician and the burial-transit			as a consequence o	f):				
	cate b	dical	d						
o X	that the death certificate ed by the attending phys detached for use as the	sician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco	me pf pregnancy				23d. Date of de	livery
. BOX	death e atten	iciai	in the past 12 months? 1 □ Live birt	h 2□Fetal death nt at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
r Ö	at the	Phys	9 Unknown 9 Unknown						
S,	iw requires that the s been signed by the should be detache	þ	Part II. Other significant conditions contributing to deal	th but not resulting in	the underlying cause give	en in Part I.	23e. Did toba	·	to the cause of death?
ecoras,		eted	Di Tei	2	(3C/4-20)		24a. Was an		
r	sician: The law s certificate has b lirector, page 2 sh	Completed					autopsy performe	d? prior to death?	utopsy findings available completion of cause of
	an: T tificati tor, pa	a	25. Was case referred to medical			26. Place of Deat	th (Check only one)	<b>O</b> lo 1⊡Ye	s 2□No
2	nysici nis cer I direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inp	atient 2 ER/Out	patient 3 DOA Othe		ome 5 Residence	ce 6 Other (Spe	ecify)
0	Ing Pt		Larratoral S LI cliding		jury Work		28d. Describe how	injury occurred	
VISION	ttend death. ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of	finiury - At home, fan	M   1□¹ m, street, factory, office	Yes 2 No	28f. Location (Stre	et and Number or B	Rural Route Number,
2	after after Direction	Certification:	4 Homicide determined building	, etc. (Specify)	,,	1	City or Town,		and riodic various,
	To the Hospital or Attending Physician: Within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Medical Examiner: On the bas and manne	is of examination and	death occurred at the tin for investigation, in my o	ne, date and place, pinion, death occu	, and due to the cau rred at the time, dat	se(s) and manner a e and place, and du	s stated. ne to the cause(s)
	To the within To the Comple	Me	29b. Signature and little of certifier		29c. License	number	290	. Date signed (Mon	th, Day, Year)
	,			MD	5	53462	_	11/12/00	-
-	h		30. Name and address of person who completed cause	of death (Item 23a) (1	Type, Print)		) (		31001
	Sta	te	31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature	IS DOKU	bood (	coad (	olen B	orvie MV
	Registr		NOV 1 1 2007 Proces	, B. An	eve				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5 9 per fb 9873 11-26-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Day Campbell

Physician /Medical Examiner

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene.

nnt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ral", or Items 23a or 28a-f show Examiner must be notified at the Medical other traumatic

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Vital Records,

0

Division

**Physician** /Medical Examiner

death certificate be executed burial-transi and the as attending use for detached the pe has page 2 certificate director. this After the

The law requires that the Physician: or Attending 24 hours after death e Funeral Director: filled in by Hospital within 24 0

1. Decedent's Name (First, Middle, Last) Justin 3 2007 11 7:20p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Future care Sandtown Winchester Baltimore NA 5. Social Security 10 75 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State rthplace (State or Foreign 1**X**M 2□F Months Days Hours Min 219-66-<del>9701</del> 74 12-23-1932 Jamacia Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1X Yes 2 No Baltimore Director Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 1309 Division Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☑ Married Yes 2 No 1 ☐ Yes 2 No Specify Completed by Specify. Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Southern Galvinizing Co. Machinist 12th grade lyr. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Campbell Geraldine Edgar Hilton ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 1309 Division Street, Baltimore, Md. Sylvia Campbell Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any Injury or ot Burial 2 □ Cremation 3 □ Removal from State 11-10-07 Randallstown, Md. Qonation 5 ☐ Other (Specify) King Mem. Pk. 21 re of Funeral Service License 22. Name and Address of Facility igna March F.H. East 21202 1101 E. North Ave., Baltimore, Md. h1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ne liate Cause (Final ing in death) for as a cons (cur use of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that initiated events resulting in death) Last (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 4 Winknown 1 TYes 2 □ No 3 ☐ Probably Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and addr completed cause of de (Item 23a) (Type, Print) 31. Date filed (Month) 32. Registrar's Signature State 200 4 Registrar

DHMH 17 Rev 1/2001

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Physician	_	egistrar . Decedent's Name (First, Midd	le,Last)	-				2. Date of Deat	200	3. Time of Death	
Medical Examine		Stephen Cons	stantine					Month November	1, 2007	2150 hrs	
4	4	la. Facility Name (if not institution	on, give street and numb	per)		4b. City, Town	, or Location of I	Death	4c. County of Death		
* 1	н	1375 Deanwood Road	d			Parkville	4,0		Baltimore Cou	inty	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1			h(MM/DD/YYYY) 9. Bir Foreig	nn	
Director	1	215-54-3631	1 XM 2 F	57	1	rs. Months I	Days Hours	Min. Dec 1	5, 1949 Co	Maryland_	
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any	Γ	10a. State 10b. County		10c. City	y, Town or Lo	cation				. 10d. Inside City Limits	
nd show	_	MD Balt:	imore	Pa	arkvill	Le				1 Yes 2 X No	
aryla 8a-f	5	10e. Street and Number				10f. Zip Coo	ie	10	g. Citizen of What Cou	ntry?	
tith the Maryland 23a or 28a-f show notified at once.	DIrector	1375 Deanwood	Road				21234	100	USA		
with t	_ L	11. Marital Status	12. Was Deced					? ( Specify Yes or No-		rican Indian, Black,	
item item	Fune	1 X Never Married 2 M	Married Armed Ford	ces? 2 X No		f Yes, specify Cu	iban, Mexican, F	Puerto Rican, etc.)	White, etc.		
Rer d		3 Widowed 4 Div	vorced If Yes, Give Year	- <u>A</u>	1	Yes 2 X	No specify:		Specify:	white	
urs a itura amir	핡	15. Decedent's Education (Spe	ecify only highest grade	completed)	16a. Dece	tent's Usual Occ	upation (Give kir	nd of work done	16b. Kind of Business	Industry	
72 ho	eted	Elementary/Secondary (0-12)	) College (1-4	or 5+)	auring	most of working	lille. DO NOT us	se retired)		2.5	
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5-0036 led within 7 Hygiene. to ther than	<u>5</u>	17. Father's Name (First, Middle	e, Last)				18.Mother's	Name (First, Middle, I	Maiden Surname)		
21 be fill rked	Re	Henry Frankli		ne				Elizabeth_			
21 ould I ould I s mar	0	19a. Informant's Name/Relation:				• ,			nber, City or Town, State		
MD d 2 sho		Mark Constant	ine/brother						s Mills, MI		
Heal Titen		20a. Method of Disposition  1 Burial 2 Crematio	n 2 Romaval from			oosition (Name of other place)	of cemetery,	Date	20c. Location - City o	r rown, State	
nol ages ant of nt: I		1 Burial 2 Cremation 4 Donation 5 X Other S	_								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	h	21. Significant of Funeral Significant			2	2. Name and Add	ress of Facility	1 (55 17	D 1. 1		
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Physician	7	23a. Part I. Enter the disease, o	or complications that cau	sed the deat	th. Do not ent	er the mode of d	ying, such as car	rdiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and	
Medical		failure. List only one cause Immediate Cause (Final diseas	O44 C	shot Wou	nd of Hea	d				Death	
aminer	-	or condition resulting in death)	Due to (or as a c								
4	-	Sequentially list conditions,	b								
	ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence	of):						
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x 6	sicia	past 12 months?	7	nt at time of	death 5	Other (Specify	)		1d.	1	
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	اج	1 Yes 2 No 9 U	9 GIIKIIOV								
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res th	ğ							1Ye		obably 4 Unknown	
cords, P.O. law requires that the has been signed by 2 should be detach	ee							24a. Was		autopsy findings available completion of cause of	
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		25. Was case referred to medic	ral	-		26	Place of Death (		- 4		
fital sician:	Be	examiner?	Haspital:	patient 2	ER/Outpat		Other	Nursing Home 5	Residence 6 🗸 Oth	er: Scene	

Division of Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Medical Certification: To

29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number O.C.M.E.

28c. Injury at Work?

1 Yes 2 🗸 No

29d. Date signed (Month, Day, Year) November 2, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1375 Deanwood Road, Parkville, MD

28d. Describe how injury occurred

Subject shot self

person who completed cause of death (Item 23a) 30. Name and address Ana Rubio MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

1 Yes

27. Manner of Death

3 V Suicide

Accident

Homicide

No

5 Pending

Investigation

Could not be determined

32 Registrar's Signature

Inpatient 2

(Specify) Townhouse / Rowhouse

28a. Date of Injury (Month, Day,Year) FOUND:

Nov 1, 2007

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

FOUND:

2145 hrs

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ONEMBER 11, 2007 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL SECOUR BALTIMORE BON if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 216-36-8980 SEPTEMBER 8,1932 NORTH CAROLINA **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 XYes 2 No SALTIMORE MARYLAND Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be SMAILWOOD U.S.A. Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Be Completed by Specify: 73 LACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES PERSON DEPARTMENT STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental HENDERSON RUSSELL LEMAY WOODRUFF ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S f Health a tem 27 is KATHY THOMPSON (DAUGHTER) 4750 COYLE RD, OWINGS MILLS, MD 21119 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of = 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 11-16-2007 BALTIMORE, MARYLAND important: If any injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217 retrich N. W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final reas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the burial-P.O. Box 68760. Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy or Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? /es 2 No 1□ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury s after dea. 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 8,2007

5

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32 Registrar's Signat

person who completed cause of death (Item 23a) (Type, Print)

NOV 1 4 2007

30. Name and address of



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08427 State of Maryland / Department of Health and Mental Hygiene Anthony J Cucina Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 30, 2007 0417 hrs Medical Examiner Anthony Cucina c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2526 McElderry Street 9. Birthplace (State or unk 8. Date of Birth (MM/DD/YYYY) If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number un 1 6. Sex Foreign **Funeral** Min. Hours Months Days Country) Director 63 23 1X M 2 Oct. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 X Yes 2 No Baltimore MD 23a or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 2526 McElderry Street 21205 US<u>A</u> 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nouneral unk 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk Armed Forces? 1 Never Married Married Yes Yes 2 X No specify: Specify: white Yes. Give Yea 3 Widowed "natural", Δ Divorced ₫ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done nkunk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) If item 27 is marked other than ' her traumatic event, the Medical 21215-0036 unk unk ment of Health and Mental Hygiene 18.Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21201 Penn Street Baltimore, O.C.M.E. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) Cremation 3 Removal from State Burial 2 Donation 5 X Other Specify: 22 Name and Address of Facility S nature of Funeral Service Ronal d State Anatomy Board Baltimore, MD 2120 655 W. baltimore Street Baltimore, MD t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Liner Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED tending physician a UNPENDED The law requires that the death certificate be 23d. Date of delivery Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Ś Diabetes Mellitus Completed 24b. Were autopsy findings available 24a, Was an should ! prior to completion of cause of autopsy death? certificate has breetor, page 2 sh performed? 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 🗸 Other: Scene DOA ER/Outpatient 3 Inpatient 2 this 1 🗸 Yes No ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2 No 1 V Natural Pending Fo the Funeral Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3 Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 30, 2007 O.C.M.E buna 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD strar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 1

DHMH 17 Rev 1/2001 OCME 2006 **Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical Examiner To Be Completed by Funeral Director

Please	Type or Prin					•	
For State	State of Ma	aryland / Dep	partment of F ertificate of I		Mental Hygie	ene	
1 - State Registrar  1. Decedent's Name (First, Middle, Late	st)	Ce	er unicate of i	Dealli	2. Date of Death	2007	3,635.2
MANUEL CEPE		7.			Month NOVEMBE	R 11, 200	07 5:00 a ^M
4a. Facility Name (If not institution, give			4b. City, Town. o	r Location of Death		4c. County of De	
STELLA MARIS			TIMON				TIMORE
5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Foreign
210-31-3404	MM 2□F	68 Yrs.	World Days	Hours With.	JAN. 7,	1939 Pi	UERTO RICO
Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	IMORE		NDALK				1 □ Yes 2 🛣No
10e. Street and Number	THOKE	ועם	10f. Zip Code		100	g. Citizen of What C	Country?
7300 DUNLAWN C	OURT AP	T. A	212	22		U.S.A	
11. Marital Status	12. Was Decedent		. Was Decedent of H	ispanic Origin? (Sr	pecify Yes or No-	14. Race - Am	nerican Indian,
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give	No	If Yes, specify Cuba 1 X Yes 2 □ No	Capaita		Black, Wh	nite, etc.
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			PUE	RTO RIC		HITE
15. Decedent's Ed (Specify only highest gra	ducation ade completed)	i (Giv	edent's Usual Occup	durina most of work		6b. Kind of Busines	s/Industry
Elementary/Secondary (0-12)	College (1-4or 5	i+)	DO NOT use retired NGINEER	1)		STATE O	F MARYLAND
17. Father's Name (First, Middle, Last,	)		_, ~,111111	18. Mother's Nam	ne (First, Middle, Ma		- MANT HAND
	PEDA			MAXI		CRUZ	
19a. Informant's Name/Relationship (	Type. Print)	19b. Ma	iling Address (Street	and Number or Ru			, Zip Code) 21244
DONZIEE CEPEDA	/ DAUGHT	I	8A VALLE				
20a. Method of Disposition	Demoual from Ct.	20b. Place of Dis				Oc. Location - City of	<u> </u>
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			CREMATO		3/07 B	ALTIMORI	E, MARYLAND
21. Signature of Funeral Service Licer	nsee		22. Name and Addre LILLY & 1901 EAS	ŽĖILER TERN AV	INC. FU	NERAL HO	OME
23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	I the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Immediate Cause (Final disease or condition		YOPATHY					Onset and Death
resulting in death)	- u.	a consequence of):					
Sequentially list conditions,	b						
if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as	a consequence of):					1
that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
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	d						
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		20			23d. Date of d	delivery
in the past 12 months?		2 Fetal death 3	Electopic pregnancy	/		Month	Day Year
9 Unknown	9□Unknown						
Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
					1 ☐ Yes	2 □ No 3 □	Probably 4X Unknown
					24a. Was an		autopsy findings available
					autopsy perform 1 Yes 2	ed? death	o completion of cause of ? es 2 □ No
25. Was case referred to medical				26. Place of Dea	ith (Check only one		00 20110
examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpati	ent 3 DOA Oth	er.	ome 5 Resider		pecify) HOSPICE
27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da				28d. Describe hov		2002 100
2 Accident investigation	n		M 1 🗆	Yes 2 □ No			
3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of inj	ury - At home, farm, s	street, factory, office		28f. Location (Stre	et and Number or	Rural Route Number,

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

29a. Certifier

(Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c License number 29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year) NOV 1 4

32. Registrar's Signature



State Registrar

Physicia /Medic Examin

Funeral Director

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physlclan: The law requires that the death certificate be executed

				Cert	tificate of i	Death		Reg. No.	2007	36353
. Decedent's Name (Fi	irst, Middle, Last)	)					2. Date of De Month	ath Day	Year	3. Time of Death
		Renae	Carlotta	Chis	holm		Novem	ber	8,200	7 0851A M
a. Facility Name (If not	1 1	1 0	( D 11		4b. City, Town, or	Location of Death	Cal	4c. (	County of De	
Social Security Numb		pital	of Delt Age (In yrs. last	hirthday	If Under 1 Year	Hrnore If Under 24 Hrs.	8. Date of Birl	b	I o P	N/A
213-62-45	. 1Г	M 2/2 F	53		Months Days	Hours Min.	(Month, Da	y, Year)		irthplace (State or Foreig Country) Maryland
sual Residence of Dec			33				Sep II	J, 1952	+	iviaiyiaiiu
a. State 10	b. County		10c. City, To	own or Loca						10d. Inside City Limit:
Maryland	N/	Ά			Ba	altimore				1 Nes 2 Ne
e. Street and Numbe					10f. Zip Code	04040		10g. Citiz	en of What C	
1318 North L			at Ever in II C	10.14	/ac Dacadant of L	21213	if-	T 4		S.A. nerican Indian,
. Marital Status  1 XNever Married		12. Was Decede Armed Force	s?	lf. lf	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)	_   '	Black, Wh	
3 ☐ Widowed 4 ☐		1 ☐ Yes 2[ If Yes, Give Year or Date	s:	11	□Yes 2□XNo	Specify:			Specify:	Black
15.	Decedent's Edu	cation	16	6a. Decede	ent's Usual Occup	ation	lein a	16b. Kin	d of Busines	s/Industry
Elementary/Secondar	nly highest gradery (0-12)	e completed) College (1-4d	or 5+)	life. Do	O NOT use retired		king	Unit	ted State	s Postal Service
12		J= (			Sup	pervisor				
7. Father's Name (Firs		Chichalm				18. Mother's Nam			,	
	Nathaniel								hisholm	
9a. Informant's Name.  Natasha Mido		pe. Print)	1	•	,	and Number or Ru Road Baltimo				, Zip Code)
a. Method of Disposit			20b. Place		ition (Name of	TOAG DAIGITIC	Date Date			or Town, State
1 ☑ Burial 2 ☐ C	remation 3 □ R	temoval from Sta	come	etery, crema	atory or other plac	of, i	11/13/07		-	r Mill, Md.
4 □ Donation 5 □  1. Signature of Funera		1.	>		Memorial Pa	ark	11/13/07		VVIIIGOO	i lami' tarer
477				22.	Name and Address	ss of Facility				
11/01/6	$\neg$	// De	Lan	22.	Name and Addres	rothers Fune	ral Service,	P. A.	~	
P rt1. Enter the d	isease, or comoli	icalions that caus	ed the reah. D		Estep B 1300 Eu	rothers Fune Itaw Place B	altimore, Mo	12121	7	Approximate
shock, or heat fa nmediate Cause (Fina	ilure. List only or	ica ions that caus ne cause on each	sed the de vih. D		Estep B 1300 Et r the mode of dyin	rothers Fune utaw Place B ng, such as cardiac	or respiratory a	2121 rest,		Approximate Interval Between Onset and Death
shock, or hear fa nmediate Cause (Fina isease or condition	ilure. List only or	ne cause on each	sed the rech. Do line.	5 o not enter	Estep B 1300 Et r the mode of dyin	rothers Fune utaw Place B ng, such as cardiac	or respiratory a	2121 rest,		Interval Between
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State

Registrar

31. Date filed (Month, Day, Year) NOV14 2007



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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician COHENS DORIS 01 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) No. Carolina 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Director 63 Mar 31, 1944 215-40-8978 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ms 23a or 28a-f show 1 Yes 2 □ No **Baltimore** Director N/A Maryland 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 21239 U.S.A. 1357 Pentwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Catholic Church Elementary/Secondary (0-12) Cook permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other th any Injury or other traumatic event, the once. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Epps James Epps ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1357 Pentwood Road Baltimore, Maryland 21239 Hampton Cohens Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Halifax County, No. Carolina 11/15/07 4 □ Donation 5 □ Other (Specify) White Oak Church Cemetery 21. Signatura | Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** /Medical Due to (or as a consequence of): **Examiner** CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by RENAL DISEASE 1 Tyes 2 No 3 Probably 4 ☐ Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

6

Registrar

State

29c. License number RES DOD 29d. Date signed (Month, Day, Year) 200

, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUD.; BALTIMORE, MD TAKER A. ABOU-KHAMIS, 5601 LOCH RAVEN BUD.; BALTIMORE, MD

31. Date filed (Month, Day, Year) NOV 1 4 2007

WEE

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 0140 AM Willa Demrey 01 November 2007 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Hanes 0 MO( If Under 1 Year Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🗖 F unk Yrs. Director 214-22-1244 81 Apr 9, 1926 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 740 Poplar Grove Street Completed by Funeral 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates: Specify: black 3√2 Widowed 4 □ Divorced "natural", un DILL other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Menta item 27 is marked 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Hospital 900 S. Caton Avenue Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4□Donation 5♥Other (Specify) in state 21. Signature of Juneral ryice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Midector in Baltimore, MD 21201 If mer the mode of dying, such as cardiac or respiratory arrest, 23a. Part1 Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respired 1089 Duylo (of as a yonsequing e of) Physician resulting in death) edical aminer el overloa Securitielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) selo ed by the attending physician and detached for use as the burial-tran onsequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 nonths? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 18 non 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 ☐ Unknow been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Malnourshm certificate 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 uneral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Μ 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined

Box 68760. DEMREY

Saltimore, Maryland 21215-0036

Division or Vftal Records, P.O. death

To the Hospital or Attended within 24 hours after death To the Funeral Director:

Registrar

filled in by

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

AMARINDER

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type

Ave Baltimore, MO

31. Date filed (Month, Day, Year) 2007 NOV 1 4

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
ANA BD G873 11/14/07 III
Reg No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0153 M NOV 7ھن2 Aubrey Mitchell Davis /Medical 4b. City, Town, or Location of Death 4a./Facility Name (If not institution, give street, and number) 4c. County of Death Examiner Pedica enter disburs licomico Kegiona If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 😾 F Director 218-12-1385 85 Sept 18, 1922 Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Worcester Pocomoke City Director 10e. Street and Number 09 Winters 10f. Zip Code 10g. Citizen of What Country? Quarters Drive 21851 Funera USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ĺ2 school assistant education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hershel Goodnite Mitchell Corilla Mary Farnsworth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward V. Davis/spouse 109 Winter Quarters Drive Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 Donation 5 ☐ Other (Specify) 21. Sign the of Euneral Struce Licensee Round S. Wales Facility State Anatomy Board 655 W. B

22. Name and Address of Facility State Anatomy Board 655 W. B

Baltimore, MD 21201

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of reach failure. List only one cause on each line. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 32045 subdural hematore /Medical Due to (or as a consequence of): fall from **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disk to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of): nding physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. #TN 2 No 3 Probably 4 Unknown 1 Tyes

**Physician** 

Baltimore, Maryland 21215-0036

page 2 s has

this After death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

or Attending

To the Hospital

Completed by Physician/Medical Be P Certification: 1 Natural 2 Accident 3 ☐ Suicide

24a. Was an autopsy performed 1∐ Yes 2 No 26. Place of Death (Check only one)

Salisbur

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year) 11/4/07 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

hurch

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Injury 1300

1 ☐ Yes 2 💆 No

28d. Describe how injury occurred

Fall down Steps Location (Street and Number or Rural Route Number, City or Town, State) Poconche 7333 Menonite Church Rd MO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of cert

4 Homicide

29a. Certifier

Medical

State

Registrar

29c. License number 45049 29d. Date signed (Month, Day, Year)

W021801

30. Name and address of person pleted cause of death (Item 23a) (Type, Print)

heis 31. Date filed (Month, Day, Year) NOV 1 4 2007  $\mathcal{D}\mathcal{O}$  . 100 E. Registrar's Signature

and manner stated.

Carroll

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** :20 AM Joseph C. Dawson /Medical County of Death 4b. Gity, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Kimico enter rainal Medical )alisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours M 2 ☐ F 106-22-2367 78 Yrs. 07/16/1929 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b County "natural", or Items 23a or 28a-f show idical Exa⊡lner must be notified at 1 □Yes 2 No East Islip NY Suffolk Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11730 USA 127 Sherry Street Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 [XYes 2 ☐ No If Yes, Give 1946–1950 Year or Dates. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Product Technician Postal Supplies permit. Pages 1 and 2 should be filec. Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, ; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roselle Litterst Irvina Dawson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 127 Sherry Street, East Islip, NY 11730 Agnes Dawson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pinelawn, NY Pinelawn Memorial Park 11/16/2007 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thorosilensis Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-tran Due to (or as a consequence of): the SS IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 **X**No 1∐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 일

Division or Vital Records, P.O. Box 68760;

funeral After To the Hospital or Attending death. d in by the within 24 hours aft To the Funeral DI completely filled in

Registrar

Certification:

Medical

28a. Date of Injury

(Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

5 Pending investigation

6 ☐ Could not be

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accounted at the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #2,3,&26, perMD,G873, 11 Certificate of Death Registrar Registrar 2. Date of Death Oct. 24, 2007 1. Decedent's Name (First, Middle, Last) Physician FREF ZIONN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIV. OF MARYLAND HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ⊈es 2 □ No **Funeral Director** MD timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural;" or Items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event. 15A 34 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition
1 Borial 2 A Cremation 3 Removal from State MB. 20c. Location - City or Town, State 5 Other (Specify) 4 Donation 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) PREMATURITY EXTREME **Physician** /Medical Due to (or as a consequence of): **Examiner** HYPOTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the death certificate be executed HYPOTHERMIA physician and s the burial-trant Due to (or as a consequence of): Box 68760, Physician/Medical BRADICAROIA as attending p IF FEMALE If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9□Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Tyes 2 11 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2∐ No 1□ Yes 21☑No 1 TYes Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Year Injury 1 Natural NIA To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al gompletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10,23,2007 D64730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S.GREENE ST, BALTIMORE, MD 21201 MEZU-NDUBUISI 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 14

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itial of paryland, be after the 2874 12-5-07 vt State
Registrar Amend 10a, perFH, g873, 11/14/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wilbur Francis, Fenwick Day Year **Physician** WILBUR 12,2007 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER FOR HOSPICE CARE BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 218-28-1383 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Maryland 1 ☑ Yes 2 ☐ No Director HOWARD COLUMBIA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21046 7357 Edenbrook Drive U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 XYes 2 No If Yes, Give 3/29/51 Year or Dates: 3/4/54 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No 2 Specify: BLACK 3 Widowed 4 Divorced 3/4/54 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FENWICK MARY DORSEY WILLIAM Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra (WIFE) 5963 TURNABOUT LN, COLUMBIA, MD 21044 ADDIE L. FENWICK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11-16-2007 CROWNSVILLE, MARYLAND 4 Donation 5 Other (Specify) <u>Crownsville</u> 22. Name and Address of Facility
505EPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTIMORE, MD 2 21. Signature of Funeral Service Licensee ietich N. Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** are /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dea To the Funeral Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of coutifier November 13, 2002 30. Name and address of person who comcleted cause of deals (Item 23a) (Type, Print) N. Charles St. Balto. Md Z1204 A.Riles 6701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:00 P M Day Month November Margaret Μ. Fonte 10 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Keswick Nursing Center Baltimore

7. Age (In yrs. last birthday)

10c. City, Town or Location

81

12. Was Decedent Ever in U.S Armed Forces?

1 ☐ Yes 2 1 No If Yes, Give Year or Dates:

1 □ M 2 X F

10b. County

If Under 1 Year I If Under 24 Hrs.

Days

Baltimore

21230

10f. Zip Code

1 ☐ Yes 2X No

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

8. Date of Birth (Month, Day, Yea. 1/28/1926

Birthplace (State or Foreign Country)

White

10g. Citizen of What Country?

Specify:

USA

14. Race - American Indian

Black, White, etc.

MD

10d. Inside City Limits

1X Yes 2 □ No

**Physician** /Medical **Examiner** 5. Social Security Number **Funeral** 219-18-8171 Director Usual Residence of Decedent 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Director 10e. Street and Number 1124 East Fort Avenue Funeral 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed filed within 7 Hygiene. d 2 should be filed w th and Mental Hygier 7 is marked other th Be 2 permit. Pages 1 and 2 st Department of Health and Important: If item 27 is m any injury or other traum Physician

/Medical Examiner

burial-transit and physician the as attending p ed by the a certificate has been si rector, page 2 should funeral director, After this

P.O. Box 68760,

Division or Vital Records,

death certificate be executed e Hospital or Attending Pi 24 hours after death. e Funeral Director: After the etely filled in by the funera within 24 hours at To the Funeral Completely filled

16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Riddell Dora Kirby Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1519 East Fort Avenue, Baltimore, MD 21230 Marlene H. Vogel / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 11/14/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Victor P. Doda Charles L. Stevens Funeral Home Inc. 0,00 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-Stage demention Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ anteresselvola cardialasentos 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No aurase 24a. Was an perform 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes / 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Nevember 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teo W. 40 th STREET, BALTIMINE, MD 21211 MARSREGIR 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 Registrar 2007

DHMH 17 Rev 1/2001

D

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12, 8:35P M 2007 Nov. Yvonne Giguere /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Under 1 Year I If Under 24 Hrs. Manor Care Ruxton 8. Date of Birth (Month, Day, Year) 09.26.1932 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 M 2 Months Days Hours Min. 213.30.7161 75 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 U.S.A. 7001 N. Charles Street by Funeral death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 DXNo White Specify 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any finjury or other traumatic event, the once. Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Anastasia ဥ Noeth <u>Joseph John Maisch</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Cresthaven Pl. Simpsonville, SC 29681 Greg Cornwell/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11.14.07 | Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility Cremation And Funeral Balto Alternatives 8717 Green Pastures Dr. MD 21. Signature of Funeral Service Licensee Molly 3 40 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 2□ No 1 ☐Yes 1☐ Yes 2 No the Hospital or Attending Physician: **Director:** After this certific in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours and To the Funeral Dir 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ulknerMD

DHMH 17 Rev 1/2001

VONNE MONNE

SIGUERE,

16565N.

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date, signed (Month, Day, Year)

Charlestreet Suite 209/Bacto ND 21204

200

07-08130 Jackie Soloma	n Gib	Please Type or Print in Black Indelible In State of Maryland / Department of		lygiene
		1- For State Certificate of Registrar		Reg. No. 2007 363
Physic		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 1354 bas
Medical Exam	iiner	Sackie Gibbs	4b. City, Town, or Location of Death	Month Day Year 1351 hrs Cotober 18, 2007 1351 hrs
		Prince George's Hospital Center	Cheverly	Prince George's
Funera		5. Social Security Number 111 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24Hrs	s. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Directo		1 M 2XF 56 Yrs	Months Days Hours Min	Oct 14, 1951 Foreign Un
		Usual Residence of Decedent	<u> </u>	000 14, 1991
r any		10a. State 10b. County unk 10c. City, Town or Locat		10d. Inside City Lim
and Shov	٥	VA Fairf	ax	1 Yes 2 X
Mary Mary	Director	10e. Street and Number	10f. Zip Code 22030	10g. Citizen of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatte event, the Medical Examiner must be notified at once.	<u>E</u>			USA
tems st be	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 13. Was lif Y	as Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto	
ter de ", or i	교	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:	Specify: black
urs af Itural	d by	lor Dates:	nt's Usual Occupation (Give kind of	work done 11nk 16b. Kind of Business/Industry
72 hc n "ns	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use reti	tired)
5-0036 led within 7 Hygiene. other than	Completed	unk unk		
15-C	ြပ္တို		unk 18.Mother's Name	ue (First, Middle, Maiden Surname)
2121 wild be fi Mental marked	o Be		Q Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
2 should and 3	12		l Penn Street Ba	
e, M and 2 Health a item 27	8	20a. Method of Disposition 20b. Place of Dispos	sition (Name of cemetery,	Date 20c. Location - City or Town, State
nor ages at of		1 Burial 2 Cremation 3 Removal from State crematory or ot	ner piace)	
Baltimore, permit. Pages I an Department of He Important: If the		21. Shipnature of Funeral Service Licensee 22. Shipnature of Funeral Service Licensee 32. Shipnature of Funeral Service Licensee 32. Shipnature of Funeral Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Ser	Name and Address of Facility	d 655 W. Baltimore Street
	1 3	Ba:	ltimore, MD 2120	01
Physiciar		23a. Pan I. Enter the disease, or complications that caused the death. Do not enter t failure. List only one cause on each line.	he mode of dying, such as cardiac of	or respiratory arrest, shock, or heart Approximate Inter Between Onset a
/Medica xamine		Immediate Cause (Final disease a. NArcotic intoxication		Death
		or condition resulting in death)  Due to (or as a consequence of):		
	e e	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		
	를	Course Er ter Underlying Course (Disease or injury that initiated		
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	led	WENDED #25a,27,28a-f, perME,g87.  IF FEMALE: 23c. If yes, outcome of pregnancy	3, 11/15/0/ TT _	23d. Date of delivery
ital Records, P.O. Box 68760, itian: The law requires that the death certificate be scerificate has been signed by the attending physici scerificate has been signed by the attending physici secrificates as the built.	sician/Med	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregn.	
Box ( death ce the attence ed for use	sici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 0	ther (Specify)	
the de ched the	Phy	5 Olikilowii	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
P.O.	5	,		1 Yes 2 No 3 Probably 4 V Unknow
ds, equire	ompleted			24a. Was an 24b. Were autopsy findings availa
of Vital Records, ng Physician: The law requir ufter this certificate has been s meral director, page 2 should l	直			autopsy prior to completion of cause of death?
Re The ifficate	8	OF Was and referred to medical	26.Place of Death (Check	1 Yes 2 No 1 Yes 2 No
Vital ysician his cert directo	B B	examiner? Hospital: 1 Inputiont 2 FP/Outpution	Othor	ing Home 5 Residence 6 Other:
of Vi ing Physi After this	<u>P</u>	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how injury occurred
on on ath.	흲	1 Natural 5 Pending FNd 10/18/2007 Fnd 1:1	1 Yes 2 X No	unk
Division tal or Attendi rs after death. at Director: /	ertification	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, stre		28f. Location (Street and Number or Rural Route Number, Cor Town, State) Marvin Gave Park Divis
Dital of ours af	erti	4 Homicide determined (Specify) found in park		Ave. NE Washington, DC
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Divictor: After this certificate has been signed by the attending physici conhetely filled in by the funeral director. page 2 should be detached for use as the burit.	alc	20 - Carliforn	rred at the time, date and place, and	nd due to the cause(s) and manner as stated.
To the within To the	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.		
	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		JM1. 1/2	O.C.M.E.	October 19, 2007
_		30. Name and address of person who completed cause of death (Item 23a)	nn Stroot Politimere MD 2	21201
فنسيب		Jack Titus MD. Deputy Chief Medical Examiner 111 Per 31. Date filed (Month, Day, Year) 32. Figure 32. Signature	,	.1201
Regi		NOV 1 A 2007	ale .	
		MAN T IS LIMIT TO SELECT THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE T		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36363 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 16:09 M 04 2007 NOVEMBER William Ganzzermiller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. SAINT AGNES HOSPITAL 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday **Funeral** 1**∑**M 2□F 220-82-4084 Dec 28, 1959 Director 47 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1√ Yes 2 No Director Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or 7 21229 USA 22 S. Athol Avenue Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23. Completed by Funeral ral", or Items 2 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 XNever Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) entertainment musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Ganzzermiller Lorraine Birdsong ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Julie Crawford-Guy/health_agent 1412 W. Lombard Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ② Other (**pecify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approxima 21. Signal of Funeral Scale Licensee Romand S. Wade Director 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) **Physician** WEEK /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been rector, page 2 should MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform within 24 hours after death. To the Funeral Director: After this completely filled in books. 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Minpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

SANZZERMILLER

WILLIAM

29b. Signature and title of certifier 29c. License number 22525

29d. Date signed (Month, Day, Year) NOVEMBER, 04, 2007

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ISHAQ SAIDU

900 CATON AVENUE, BALTIMORE, MD 21229

State Registrar

NOV 1 4

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend item 1 per doc 9873 11-14-07 yt State of Maryland 7 bepartment of Health and Mental Hygiens 0 0

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Year 2007. 11:454M
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10d. Inside City Limits 1 ☐ Yes 2 ဩNo
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(Month, Day, Year)

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	Director		218-32-6512	□M 200 72	Yrs.	Months Days	Hours Min.	(Month, Da	iy, Year) 27 <b>,</b> 1935	Mary	yland	
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deeth	me 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.		Iispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rac	ce · Americar	n Indian,	
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ש –	Item othe		20a. Method of Disposition		lace of Dispo	sition (Name of matory or other place	Į.	Date	20c. Location		m, State	
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permit.	Department of friportent: If Its any injury or o		21. Signature of uneral Service higens	by M			ss of Facility Funeral					
			23a. Part1. Enter the disease, or comp	lications that caused the death			Ave. Du				Approximate	
Ph	ysician		shock, or heart failure. List only of Immediate Cause (Final		21100	XUA TAN	912 IN	calin	TON		Interval Between Onset and Death	
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	n		30. Name and address of person who 9	ompleted cause of death (Item	23а) (Туре,	Print)					10-2007.	
	J			D. 7445 FU	RNACE	BRANCH	Rd - 64	NBUR	VIE MA	4101	60.	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signal	ture							

State Registrar

32/Registrar's Signature

NOV 1 4 2007

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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Amend #23a&b	State of Ma Per Phy G	ryland / Dep 3873 11 <i>/</i> ዚ/	artment of F	lealth and Death	Mental Hy	giene	07	36365
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15	Funeral Director			M 2□F	52 Yrs.	Months Days	Hours Mir		y, Year)	Country	Virginia
	64		Usual Residence of Decedent					December	1, 1994		
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21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:19	o	If Yes, specify Cub  1 ☐ Yes 2 No	an, Mexican, Pue Specify:	erto Rićan, etc.)		ck, White, etc v: Whit	
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Bal	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licens	<b>'</b>	M01473 R	22. Name and Address ockville, ockville,	Inc., Marylar	bert A. 300 West nd 20850-	Pumphre Montgom 2805	y Fune ery Av	ral Home/ venue,
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused to ne cause on each line	the death. Do not er a.	nter the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,	l. li	Approximate nterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hecko	splast	c 3900	NO IVE	Leukemia			3 months
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	90	je.	Sequentially list conditions, if any, leading to immediate	b	dysplast: consequence of):	ic Syndro	owe				
	cuted nd ransit	Examiner	If any, leading to in misdiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
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9 x	leath certific attending p i for use as i	/Me	IF FEMALE:	23c. If yes, outcome p	of pregnancy				23d Da	te of delivery	,
Вох	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 2 4 ☐Pregnant at t	2 ☐ Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	У				ay Year
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ecc	e law r has be je 2 sh	ple						24a. Was	osy	prior to comp	sy findings available pletion of cause of
E H		Completed						1 Yes	rmed? 2 No	death? 1 ☐ Yes 2	□H0
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ō		-: T	1 Yes 2 New  27. Manner of Death	28a. Date of Injury	y 28b. Time	III JUDON	4 🗆 Nursing	Home 5 ☐ Resi	dence 6 LIOti now injury occur	1 1 27	
lon	Attending Ph r death. ector: After th by the funeral	tion	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		rƙ? ]Yes 2∐No				
Division	I or Attend after death. Director: A d in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (	Street and Numi vn. State)	ber or Rural I	Route Number,
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		rsician: To the best of iner: On the basis of and manner stat	examination and/or						
	o the	Med	29b. Signature and title of certifier	and marmer state	Λ.	29c. Licens	se number		29d. Date signe	ed (Month, Da	ay, Year)
	C > E 0		Mianela	Shoh		D Pla	1857		11/2/	2007	
	axl		30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type	e, Print)	•		1		
	7		Kiarach Zarbalian 22			eet, Ba	Himor	< MD	217	201	
, i	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Leo Edson Harrold, Jr. 2007 6:40P Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6767 Greatnews Lane Howard Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□F Yrs. Director .09.1929 187.22.4829 78 PA filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21044 6767 Greatnews Lane Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "n. any injury or other traumatic event, the Media once. Federal Elementary/Secondary (0-12) College (1-4or 5+) Government Psychologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruby Coole Leo Edson Harrold, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6767 Greatnews Lane Columbia, MD 21044 SAndra Harrold/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 11.14.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto M01443 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INGESTIVE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RICULAR TA CHY CARDIA CHRONIC RANAL FAIL DE 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 No certificate death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA r After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.O. Division or Vital Records, Hospital or Attending within 24 hours after death. To the Funeral Director: A completely

State Registrar

5450 KNOLL N. DRHE led (Month, Day, Year)

2007

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

(Check only one)

29b. Signature and title of certific

NOV 14

29c. License number

COLUMBIA, MO

29d. Date signed (Month, Day, Year)

			Please Type or Pri	nt in B	lack Ir	ndelible Ink.	Ensure Al	I Copies	Are Le	gible.		
			State of M	aryland		artment of H		lental Hy	giene			_
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	be filed within 72 hours after death with the Maryland Hygiene.  4d other than "natural" or Items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 311 S. Queen Street			10f. Zip Code	620		10g. Citizen		untry?	
	ns 23 must	Funeral	11. Marital Status 12. Was Deceden	t Ever in U.S	. 13			ecify Yes or N		JSA Race - Amei	rican Indian,	
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Maryland 2	D = N =		19a. Informant's Name/Relationship (Type. Print)  Elaine Barnwell/sister			ling Address (Street				wn, State, Z	Zip Code)	
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Ē	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 <b>双</b> Donation 5 ☐ Other ( <i>Specify)</i>	;	течету, ст	ematory or curer plac	(e)					
baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee  Ronaldy S./ Wade, Dir	ector	S	22. Name and Addre	ss of Facility	655 W	. Balt	imore	Street	_
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	To the To the comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date s	gned (Mont	h, Day, Year)	-
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			30. Name and address of person who completed cause of	death (Item :	23a) (Type	e, Print)	Locato	1000	A 14/	10	711-20	
	Sta	ite	3Y. Date filed (Month, Day, Year) 32 degis	trar's Signatu	ure	1 2.	140 (4)	1000	, , VV	N	21020	
	Registr	ar	NOV 1 4 2007	ie l	1 19	DENEL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08606 State of Maryland / Department of Health and Mental Hygiene John Joseph Hulme Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2007 1450 hrs Medical Examiner John Joseph Hulme c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Gaithersburg 9701 Fields Road #504 9. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Country) **Funeral** Min. Months Days Hours Director August 18, 1941 Rhode Island 1 X M 2 F 66 035-28-0707 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 1 Yes 2 X No items 23a or 28a-f show ust be notified at once. Gaithersburg Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 United States 9701 Fields Road #504 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Specify: White 1 Yes 2 X No specify: If Yes, Give Year 1960-1962 Pages 1 and 2 should be filed within 72 hours after 4 X Divorced "natural", ģ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) of Health and Mental Hygiene.

It: If item 27 is marked other than other traumatic event, the Medical 21215-0036 Plumber Plumber Plumbing 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes Patricia McIntyre Be John Himebaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 21004 Cogwheel Way, Germantown, Maryland 20876 Matthew N. Rebro/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) November 10, Burial 2 X Cremation 3 Removal from State Bethesda, Maryland Montgomery Crematorium 2007 Important: injury or ot Donation 5 Other Specify Robert A. Pumphrey Funeral Home, Rockville, Inc. 21. Signature of Funeral Service Ut Insee 300 W. Montgomery Avenue, Rockville, Maryland Musin M01173 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death Medica a Hypertensive cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and -Physician/Medical AMENDED 4,9873, 11/16/07 TT / #23a,27,perME,g874, 12/6/07 TT physician a the burial -X UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be 23d Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth signed by the attending be detached for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an ricate has been si page 2 should b prior to completion of cause of autopsy performed? death? certificate has ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Nursing Home 5 Residence 6 Other: Scene Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification Yes 2 Natural 1 X 5 Pending within 24 hours after death.

To the Funeral Director: the f 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Wild Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME O.C.M.E. November 6, 2007 okino 30. Name and address of person who completed cause of death (tem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, D strar's Signature

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DHMH 17 Rev 1/2001 OCME 2006

State Registrar

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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24H	rs. 8. Date of Birth	n/a n(MM/DD/YYYY) 9. Birth	place (State or				
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036 ithin 7 ne. r than	mpl	12th Direct	Aid CareIV		State of MD					
5-0 fled w Hygie I othe	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)									
121 Id be f fental narke event,	Charles Hall Sr.    Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smith   Anita Smit									
ID 2 shoul and N 27 is m	ďγ		Gatehouse Drive, Gwa							
e, M and 2 Tealth item 2		20a. Method of Disposition 20b. Place of Disp	position (Name of cemetery,	Date	20c. Location - City or	own, State				
nor ages ant of at: If		1 X Burial 2 Cremation 3 Removal from State MD Nationa	al Cemetery   11-		Laurel, MD					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygievic Innih Trant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	. Name and Address of Facility W	ie Funcal	HOME P.A. OF	salto. MD				
E P P		Diagram III.	200 Liberty Rd., Rand							
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the <b>d</b> eath. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardia	oor respiratory arre	est, shock, or heart	Approximate Interval Between Onset and				
caminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		<del></del> :		Death				
		b								
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
14	Examiner	(Disease or injury that initiated events resulting in death) Last								
e executed tian and ial - transit	al Ex	d								
e exection a cian a rial - 1	ıo	AMENDED AMENDED	873. 11/16/07 TT							
Box 68760, death certificate be exemble attending physician cd for use as the burial -	cian/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery Month D	ay Year				
ox 687 eath certific attending p	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pres Other (Specify)	gnancy	Month L	ay real				
Box e death the atte	Physi	1 Yes 2 No 9 Unknown a				·				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funera Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	<u>€</u>		e underlying cause given in Part I.		bbacco use contribute to					
ords, w require s been si	Completed			24a. Was		topsy findings available ompletion of cause of				
COr e law r e has b e 2 sh	힡	<del></del>		_ autop perfo	rmed? death?					
tal Rection: The certificate ector, page	ပိ		26.Place of Death (Che		2 10 1	3 2 10				
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	m	examiner?	ent 3 DOA Other Nu	rsing Home 5	Residence 6 Other					
ing Phy After th	일	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time		28d. Describe	how injury occurred					
ion trendi leath tor: /	atio	Natural 5 Pending FNd 11/10/2007 Fnd 2:		unk						
Division ral or Attendium rs after death al Director: / led in by the fu	Certification:	3 Suicide 6 X Could not be determined (Specify) Toward and Specify			Street and Number or Ru State) Lehouse Dr. Ba					
Di- ospital o hours a meral I	ဗီ	4 Homicide Getermined (Specify) Found: reside								
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (Check only one)  2 Wedical Examiner: On the basis of examination and/or invest	curred at the time, date and place, a igation, in my opinion, death occurre	and due to the caused at the time, date	and place, and due to th	e cause(s)				
To To	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	nth, Day, Year)				
		his his my	O.C.M.E.		November 10, 20	007				
ĺx.		30. Name and address of person who completed cause of death (Item 23a)			1					
10		Ling Li, MD Assistant Medical Examiner 111 Penn St	reet, Baltimore, MD 21201							
	tate	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	dis.							
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State of Maryland / Department of Health and Mental Hydiene

KUNK		State of Maryland / Department of He- For State Certificate of De		Reg. N	<u>2007 3637</u>		
Physicia dical Examin	in/	Registrar  1. Decedent's Name (First, Middle,Last)  Leonard Hunt		2. Date of Death Month Day November 8,	3. Time of Death		
dical Examin		4a. Facility Name (if not institution, give street and number)  4b. Ci	ty, Town, or Location of De		4c. County of Death		
Formula		2000 0011090 / 1101100	Ultimore Under 1 Year I If Under 24	Hrs. 8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or		
Funeral  Director	i		onths Days Hours I	Min. 08/21/1	963 Foreign NC Country NC		
ny	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
and show a	5	1.0000011	umberton		1 Yes 2 XNo		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygien and tem 27 is narked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Directo	10e. Street and Number 789 NC Highway 41 South	. Zip Code 28358	10g. (	Citizen of What Country? USA		
ath with tems 23s	uneral	1 X Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. American		
after de	by Fu	or Dotoc:	2 X No specify:		Specify: Indian		
2 hours "natur	ted t	Figure 17/2   College (1-4 or 5+) during most of	sual Occupation (Give kind f working life. DO NOT use		b. Kind of Business/Industry		
1036 vithin 72 ene. er than	Completed	9 Carr	enter	lame (First, Middle, Maid	Construction		
21215-0036 and be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Willie C. Hunt	Lula	Jane Oxend	ine		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiene. Important: If tiem 27 is narked other than "natural", or items injury or other traumatic event, the Medical Examiner must be	101	19a. Informant's Name/Relationship (Type, Print )  Lula Jane Hunt / Maother  19b. Mailing Add 789 NC	ress (Street and Number Highway 41	r or Rural Route Number South, Lumb	r, City or Town, State, Zip Code) erton, NC 28358		
e, MD I and 2 sho Health and Fitem 27 is		20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date 2	Oc. Location - City or Town, State		
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		4 Donation 5 Other Specify: Benson Cl	napel 1	1/15/2007	Maxton, NC		
Balf permit Depart Impor injury		Zi. Signatary Si. Talantary	narles I. Ste	evens Funer	al Home Inc.		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the infailure. List only one cause on each line.	ode of dying, such as card	iac or respiratory arrest,	shock, or heart Approximate Interval Between Onset and Death		
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound of Head  Due to (or as a consequence of):					
	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
50, te be executed ysician and burial - transit	ä	d					
60, ate be exe hysician	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery		
Sox 68760, leath certificate be attending physic for use as the bur	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal of Pregnant at time of death 5 Other	death 3 Ectopic pro	regnancy	Month Day Year		
Box he death c the atten hed for us	hysi	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the under		I. 23e. Did toba	acco use contribute to the cause of death?		
ires that the signed by	þ			1 Yes	2 No 3 Probably 4 Unknown		
of Vital Records, g Physician: The law requir fire this certificate has been s neral director, page 2 should I	Completed			24a. Was an autopsy perform	prior to completion of cause of		
ician: The la ician: The la certificate ha	Com		26.Place of Death (C	1 <b>✓</b> Yes 2			
Vital ysician: his certi	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	Other:		esidence 6 🗸 Other: Scene		
n of \ding Ph.h.	l H	27. Manner of Death 28a. Date of Injury 28b. Time of Injury FOUND:  28b. Time of Injury FOUND:	ry 28c. Injury at Work?  1 Yes 2 ✓ N	28d. Describe ho Subject shot	w injury occurred		
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Divetor. After this certificate has been signed by the attending phrompherely filled in by the funeral director, page 2 should be detached for use as the	Certification:	2 Accident Investigation Nov 8, 2007 1017 fts 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, to	actory, office building, etc.	or Town, Sta	reet and Number or Rural Route Number, City		
Di Iospital 4 hours of inneral		4 Homicide determined (Specify) Townhouse / Rowhouse  29a. Certifier (Cherk only 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place	e, and due to the cause	s) and manner as stated.		
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	, in my opinion, death occu	urred at the time, date ar	nd place, and due to the cause(s)  29d. Date signed (Month, Day, Year)		
	Σ	29b/ Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) November 9, 2007				
m		30. Name and address of person who completed cause of death (item 23a)	Annak Deltimorum BAD	21201			
	State	31 Date filed (Month, Day Year) 32, Registrar's Signature	treet, Baltimore, MD	7 2 1 2 0 1			
Regis		NIOVI 1 / 2001 / L PSE gran A A AGAIN					

Pleas	se Type or P			i <b>delible Ink.</b> artment of H					iibie.	
For State Registrar	otate of	iviai yianc		rtificate of			Reg.	0.0	107	3637
Decedent's Name (First, Middle	, Last)						ate of Death Month	Day	Year	3. Time of Death
	Deb	orah D.	, Johr	nson			VEMBER	11 .	2007	11:55 AM
Facility Name (If not institution	, give street and numb	ber)		4b. City, Town, or				4c. Coun	nty of Death	
	TAL OF B	ALTIM	ORE	BALTIM	IORE	CIT				N/A
ocial Security Number		. Age (In yrs. la	Vre	) If Under 1 Year Months Days		4 Hrs. 8. Da Min. (A	Date of Birth Month, Day, Ye Jan 31,		9. Birt Co	thplace (State or Foreign buntry) <b>Virginia</b>
at Residence of Decedent										10d Incid- Cit
State 10b. County	<b>A44</b>	10c. City,	, Town or Lo		Baltimore					10d. Inside City Limits 1
Maryland	N/A				- and into le		40	Citizon	f What Co	untry?
Street and Number  3617 Beehler Aven	ue			10f. Zip Code	2121					S.A.
Marital Status	12. Was Deced	dent Ever in U.S	3. 13.	. Was Decedent of H If Yes, specify Cub	Hispanic Originan, Mexicos	in? (Specify )	Yes or No-		Race - Ame	erican Indian, te, etc.
□ Never Married 2□ Marr □ Widowed 4 🏿 Divorced	ried 1 ☐ Yes 3	ces? 2 <b>12 1</b> 0 9		1 ☐ Yes 2 → Yo		rical		Spec		Black
15. Deceden	it's Education		16a. Dece	edent's Usual Occup	pation	of man.	16	b. Kind of	f Business/	Industry
(Specify only highe	st grade completed)	40r 5 · )	(Give	re kind of work done DO NOT use retire	during most o	or working			Char	n Home
lementary/Secondary (0-12)	College (1-	+∪r 5+)		Ho	omemake	١٢				
Father's Name (First, Middle,	Last)				18. Mother's	's Name (Firs	rst, Middle, Mai			
_ ,	bsey Campbell						Jean	Camp	pbell	
. Informant's Name/Relations			19b. Mail	iling Address (Street	t and Number	or Rural Ro	ute Number. C	ity or Tow	vn, State,	Zip Code)
Chanell Johnson	type. rand			3415 Barry P		i Randalls	stown, Ma	ryland	21133	
. Method of Disposition	2 []2	C	lace of Dispersion	position (Name of rematory or other pla	ice)	Date		c. Locatio	-	r Town, State
1  Surial 2  □ Cremation 4 □ Donation 5 □ Other (5	Specify)	oldie	We	estern Star Ce	emetery		1/15/07		Baltin	nore, Md.
Signature of Funeral Service	(0,9)	510	1X	1300	Brothers	s Funeral	l Service, F imore, Md	21217		
a. Parl. Enter the disease, o shock, or heart failure. Lis	r complications that ca t only one cause on ea	aused the death ach line.	o not e	enter the mode of dy	ring, such as c	cardiac or res	spiratory arrest	t,		Approximate Interval Between Onset and Death
mediate Cause (Final ease or condition	_a. PL	LMON	YARY	39KH	KTEN	KION	1			5 yrs.
ulting in death)		or as a consequ								U
quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury	b. Due to (	or as a consequ	uence of):							
t initiated events	с									-
ulting in death) Last	Due to (	or as a consequ	uence of):							
FEMALE:	220 If	come pf pregna	ıncv					224	. Date of de	alivery
b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live b	ointh 2 ☐ Feta nant at time of d	al death 3	3 □Ectopic pregnan 5 □ Other (specify)				230.	Month	Day Year
rt II. Other significant condit	tions contributing to de	eath but not res	ulting in the	underlying cause g	iven in Part I.					to the cause of death?
							1 <b>⊠</b> Yes	3 2 □ N	lo 3 🗆 I	Probably 4 □Unknow
						_	24a. Was an autopsy perform	ed?	24b. Were a prior to death?	
Management	al I				OF Dices	of Death (C		No		
. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2□	ER/Outpat	tient 3 DOA	Manu:		<i>5</i> □ Resider		Other (Sp	necify)
7. Manner of Death  1 Natural 5 □ Pend	28a. Date		28b. Time	e of 28c. Inj		28d	d. Describe hov			

Examiner Examine attending physician and bunial-trar Physician/Medical use as the for cate has been signed by the a page 2 should be detached Be Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director.

Physician /Medical

Certification: To

23b. Was dec in the par 9 Unkr Part II. Other s

1 - For State Registrar 1. Decedent's Na

4a. Facility Name

10a. State

Director

Be Completed by Funeral

10

SINAL 5. Social Securit

213-Usual Residence

Marylan 10e. Street and 3617 E

11. Marital Statu 1 Never N

17. Father's Na

**Physician** /Medical

**Examiner** 

**Funeral** Director

IF FEMALE:

25. Was case examiner?

1 ☐ Yes 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

MBBS

29c. License number 62-000

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NOVEMBER, 11, 2007

State

Medical

31. Date filed (Month, Day, Year) NOV 1 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUMIT TALWAK, SINAT HOSPITAL 32 Registrar's Signature

OF BALTIMORE

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

				Type or Prin							•	
		- 2	1 - State Registrar Amend 20b-c,  1. Decedent's Name (First, Middle, Lasi	perFH,G873,	11/20/0	7 <b>@e</b> rtifica	te of	Death	2. Date of D	Reg. No	2007	36372 3. Time of Death
E.	Physici /Medic	-		LBUR	50	SUHC	01		Month NOVEMO	Day BER	y Year 10, 2007	7:03 PM
	Examin	- 4	4a. Facility Name (If not institution, give	street and number)	SPICE			r Location of Death			County of Death	
h	Funeral Director		Social Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. S	7. Age	(In yrs. last I		er 1 Year		8. Date of Bi	irth lay, Year)	9. Birth Cou	place (State or Foreign ntry) RYLAUD
	P		Usual Residence of Decedent  10a. State 10b. County	wn or Location						10d. Inside City Limits		
	Maryla f sho	tor	MARYLAND BALTIN	NORE		LTIMO	RE					1 □ Yes 2 ☑ No
	or 28a	Director	10e. Street and Number			1	ip Code	7			izen of What Cou	intry?
	s 23a o	ral	6800 FOX MEAD					207			S.A.	and leading
36	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or Items 23a or 28a-f show event, the Merical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent 8 Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 ☑ No Specify:			0-	14. Race - Ameri Black, White Specify:	
215-0036	72 hou natura lical E	eted	15. Decedent's Edu (Specify only highest grad		16	Sa. Decedent's Us (Give kind of v	vork done	during most of wo	rkina	16b. K	ind of Business/Ir	ndustry
2121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) S	life. DO NOT	use retire	d) J DEPA	-	BA	LTIMOR	E CITY
	t Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)			11.01777	.,	18. Mother's Nar		-		
ylar	should be filed nd Mental Hygi marked other matic event, tl	To B	JACK	20	HNSC	M		ELLA	n	7.	HAL	JKINS
Maryland	12 should h and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (T			- · · · · · · · · · · · · · · · · · · ·	* .	and Number or Ri		, , ,	, ,	_
	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		DOROTHY JOHNSON (WIFE) 6800 FOX MEADOW RD, BALTIMORE, M.  20a. Method of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of									
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Baltimore,	4 Donation 5 Other (Specify)  21. Signature of Funeral Service, Licensee  22. Name and Address of Facility  33. FUNERAL PARK  34. Donation 5 Other (Specify)  25. Signature of Funeral Service, Licensee  26. Name and Address of Facility  35. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERAL PARK  36. FUNERA									HOME		
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	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC  Due to (or as	OBSTRI a consequenc	UCTIVE P		NARY DISE				Interval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
P.O. Box 6	The law requires that the death certificate be ate has been signed by the attending physicis age 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea			у		4,1	23d. Date of deli Month	very Day Year
	es that igned b		Part II. Other significant conditions co	ontributing to death bu	ut not resulting	g in the underlying	cause gi	ven in Part I.				the cause of death?
ord	w require	ted									1	obably 4∭Unknown
Vital Records,		Completed by							per 1∐ Yes	opsy formed? 2XIN	prior to c death?	topsy findings available ompletion of cause of
V.	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 🗆 Inpatie	nt 2□ER/	Outpatient 3	OOA Ott	26. Place of De			6 <b>X</b> Other (Spec	eify) HOSPICE
٥٢ ا	ding Phy h. After this funeral d	n: To	27. Manner of Death	28a. Date of Inju	ry 28t	o. Time of Injury	28c. Inju Wo		28d. Describe		, ,	ny) HOSI ICE
Division	or Atten ter deat Irector: I by the	Certification:	1 X Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide determined		ury - At home,	M farm, street, fact	1	Yes 2 No	28f. Location City or T	(Street a	nd Number or Ru e)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce		ysician: To the best hiner: On the basis of and manner sta	examination							
	To the Vithin To the Comple	Me	29b. Signature and title of certifier	)		1	9c. Licen	se number		29d. Da	ate signed (Month	n, Day, Year)
	1		)	_			D	13771	_		11/12/0	7
6	ı		30. Name and address of person who o									
7	Sta	te	DR. TARIQ - MAHMOOD  31. Date filed (Month, Day, Year)	32 Registr	LANEY V ar's Signature		D. 1	IMONIUM,	MD 210	93		
	Registi		NOV 1 4 20	107 La Car	w B	A TRANS	D					

P.O. Box 68760. Records, Division or Vital To the Hospital or Attending death.

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

6 ☐ Could not be

determined

Certification: Director: Medical

within 24 hours a To the Funeral C

Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40THS+ UV 0

and manner stated.

07-08357 Richard Lindsay

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	.e o. maryiana	Certifica	ate of	Death		, , ,	Reg	. No.	200	1 363	1
	Physicia	an/	1. Decedent's Name (First, Middle,						- М	ate of Death	Day	Year	3. Time of Death 1258 hrs	٦
Лес	dical Exami	ner	Richard Linds  4a. Facility Name (if not institution,			Lai	b. City, Town, o	or Location of I		ctober 27,		ounty of Death	12301115	4
			University Hospital	give street and number)		"	Baltimore	Location on	Deali		1-0.00	anty or Beaut		
	Funeral		5. Social Security Number un 6	. Sex 7. Age	e (In yrs. last birth	nday)	If Under 1 Ye	ar If Under	24Hrs. 8.	Date of Birth	(MM/DD/	YYYY) 9. Birti	nplace (State or unk	$\exists$
	Director			1 X M 2 F	50	Yrs.	Months Da	ys Hours	Min.	ec 14	, 195	Foreign	ר intry)	
			Usual Residence of Decedent											ゴ
	w any		10a. State 10b. County		10c. City, Town								10d. Inside City Limits 1 X Yes 2 No	- 1
	Aaryland 28a-f show any <u>1 at once.</u>	çç	MD		Bal	timo				140-	O:4:	of What Coun		_
>	e Mary or 28a fied at	Direc	10e. Street and Number				10f. Zip Code	0101=		100	j. Citizen		ury?	
2	eath with the Maryland items 23a or 28a-f sho ust be notified at once.		1036 Harlem Av		Ever in U.S.	13. Was	Decedent of H	21215	n? (Specify	Yes or No-	14.	USA Race - Americ	can Indian, Black,	$\dashv$
	eath v item	uneral	1 Never Married 2 Mar	ried Armed Forces?			s, specify Cuba					White, etc.		
	after d	by Fi	3 Widowed 4 Divor	rced If Yes, Give Year or Dates:			Yes 2X N				Spe	ec <i>ify:</i> b1	ack	
	hours natur	ᄝ	15. Decedent's Education (Specif	y only highest grade com		Decedent during mo	's Usual Occup	ation (Give kir fe. DO NOT us	nd of work ( se retired)	^{done} unk	16b. Kind	of Business/li	ndustry unk	:
	36 in 72 han "	plet	Elementary/Secondary (0-12)	College (1-4 or 5	5+)									
	5-0036 led within 72 hou Hygiene. other than "nati	Complete	unk 17. Father's Name (First, Middle, L	unk ast)			unk	18.Mother's	Name (Firs	st, Middle, Ma	aiden Sur	rname)	unk	$\exists$
	21215-0036 buld be filed within 7 Mental Hygiene. marked other than ie event, the Medica	Be (					GIII						diik	
	ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	은	19a. Informant's Name/Relationshi	p (Type, Print )	195	o. Mailing	Address (Stre	eet and Numb	er or Rural	Route Numb	er, City o	or Town, State	, Zip Code)	П
	nd 2 alth		O.C.M.E.				Penn St		altim Da			21201 eation - City or	Town State	4
	Baltimore, M permit. Pages 1 and 2 Department of Health in Important: If item 2' injury or other traum		1 Burial 2 Cremation	3 Removal from Sta		ory or oth		emetery,	Da	ie	200. LOO	ation - Oity of	Town, State	١
	t. Pag tment tment rtant:		4 Donation 5 X Other Spe	cify: in state		Loo N	ame and Addre	on of Engility						_
	Baltimo permit. Page Department of Important: injury or ott		21. Signature of Fund Service L Konald S	. Wale Jar	ector	Sta	ate Ana	tomy Bo		655 W.	Ba1	timore	Street	
	Physician		23a. Part I. Enter the disease, or co		the death. Do no	t enter th	timore e mode of dyin	g, such as car	21201 rdiac or res	piratory arres	st, shock,	, or heart	Approximate Interva	
	Medical		failure. List only one cause o	a. <b>henopericar</b>	dium								Between Onset and Death	
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	760, icate be physiciathe buris	Medica	IF FEMALE:	#23a-b,PII	ne of pregnancy	,g8/3	, 11/21/0	7 TT			23d. E	Date of deliver		
	x 687 h certifica tending p use as th		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	E Fet	al death 3	Ectopic (	pregnancy		Mo	onth [	Day Year	
	Box 68' in death certiff the attending red for use as 1	Physician	1 Yes 2 No 9 Unkn		time of death	5 Oth	ner (Specify)							
	D. B t the d by the		Part II. Other significant condition		h but not resulting	g in the u	nderlying cause	e given in Parl	t I.	23e. Did tob	pacco use	e contribute to	the cause of death?	_
	P.O. es that the igned by be detach	d by	Hypertensive	atheroscleroti	c cardiov	ascula	ar diseas	æ		1 Yes	2 N	lo 3 Prol	oably 4 🗸 Unknown	
	ords, P.C. w requires that us been signed by should be deta	Completed							- 1	24a. Was a autops			topsy findings available	
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	tal Recian: The certificate	au l	25. Was case referred to medical				26.Pla	ce of Death (0	Check only					_
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	ion of Vital Records, P.O. Box 68' tending Physician: The law requires that the death certificath. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as 1	n: T	27. Manner of Death  1 X Natural 5 Pendin	28a. Date of Inju (Month, Day,Y	ury 28b. (ear)	Time of Ir	· ·   _	ijury at Work?	1	l. Describe h	ow injury	occurred		
	ivisior or Attend after death Director:	atic	o I citali	igation		_		Yes 2 1		Laartina (C		Ni mbasa D	City Control November City	
	Division of Vital Records, Hospital or Attending Physician: The law require 4 hours after death. Funeral Director: After this certificate has been sitely filled in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	detern	not be	njury - At home, fa	arm, stree	et, factory, office	e building, etc.	. 201	or Town, St		Number of Ru	ıral Route Number, Cit	y
	Hospital 24 hours Funeral stely filler		4 Homicide  29a. Certifier 1 Certifying Physics	ysician: To the best of m	v knowledge, de	ath occur	red at the time.	date and plac	ce, and due	to the cause	e(s) and r	manner as stat	ed.	_
	Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 2 Medical Exam	niner:On the basis of examiner stated.	mination and/or i	nvestigat	ion, in my opini	on, death occ	urred at the	e time, date a	and place	e, and due to th	ne cause(s)	
	F 3 F 3	Me	29b. Signature and title of certifier	and marrier stated.	N		29c. Lice	nse number			29d. Da	ite signed (Mo	nth, Day, Year)	
			Mlina Br	assell Vi	MA		0.0	C.M.E.			Octob	per 28, 200	7	
			30. Name and address of person v			444 5	lonn Cir	Daltim ar-	MD 044	201				
		tate	Melissa Brassell, MD  31. Date filed (Month, Day, Year)	Assistant Medical	I Examiner ar's Signature		enn Street,		, IVID 2 12	201				
	Regis		NOV 1 4	2007 Elecus	00,	Spar								
				-										

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 10, **Physician** 2007 Vernon Edward Longest 1:30P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/AApt. Baltimore City 3939 Roland Ave. 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Director 75 25,1931 Maryland 216**-**28-6792 Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Baltimore City Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21211 United States Apt. 415 3939 Roland Ave. Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Tire Builder Automobile Industry 1 and 2 should be filed w Health and Mental Hygier 3m 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert A. Longest Margaret A. Warden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau Sherry Gerben (Niece) 7318 Geise Ave. Edgemere, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/12/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 1 Coven 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine executed and burial-trar Due to (or as a consequence of) attending physician pe Physician/Medical as the IF FEMALE: asn If yes, outcome pf pregnancy 1∟Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.O. Division or Vital Records,

il or Attending Physician: after death. I Director: After this certifica filled in by the 24 hours a Hospital within 24

State Registrar 29a. Certifier (Check only

29b. Signature and title of certifier t

29c. License number

**Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

730 Falls Road nnai

31. Date filed (Month, Day, Year) NOV 1 4 2007 32 Hegistrar's Signature

GORALLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07<u>-</u>08710 State of Maryland / Department of Health and Mental Hygiene James C. Linthicum 2007 36376 Certificate of Death 1- For State 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day November 8, 2007 2359 hrs James C. Linthicum Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Franklin Square Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Maryland Months Days Hours 75 Feb.7,1932 Director 216 30 8957 Yrs 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Baltimore tother than "natural", or items 23a or 28a-f show the N. ok al Examiner must be notified at once. Essex Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 21 221 740 Seawall Rd. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married Yes Specify: White If Yes, Give Year 1951/54 Yes 2 X No specify: Divorced marked other than "natural", ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Service Station Attendant 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Brown Charles Griffith Linthicum Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) M M 740 Seawall Rd. Baltimore, Maryland 21221 Shirley Linthicum (Wife) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place 1 XBurial 2 Cremation 3 Removal from State 11/12/2007 Woodlawn, Maryland permit. Pages
Department of
Important: 1
injury or othe Lorraine Park Cemetery Other Specify: ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex 21 Signature of Funeral Service Licens Maryland Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line. 'Medical Pneumonia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit requires that the death certificate be executed Physician/Medical X UNPENDED #23a,27,perME.G874, attending physician or use as the burial 12/24/07 TI 23d. Date of delivery Box 68760. IF FEMALE Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth past 12 months' Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown by ₫. Completed 24b. Were autopsy findings available 24a. Was an Records, prior to completion of cause of death? performed? has ✔ Yes 2 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 Hospital: 1 Inpatient ER/Outpatient 3 this 1 ✓ Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification

of Vital After Division dcath. Director: hours after

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in by

Medical

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number November 10, 2007 O.C.M.E.

Yes 2 X No

Death

No

36. Name and address of person who completed cause of death (Item 23a)

2007

Pending

6 Could not be

Investigation

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D.

gistrar's Signature

31. Date filed (Month Cay, Year) State Registra

1 X Natural

Accident

Suicide Homicide

29b. Signature and title of certifier

07-08685 Kelly Laulis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 36377 Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 8, 2007 1040 hrs **Medical Examiner** Kelly Laulis 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Dundalk 7324 Kirtley Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours country) England 02/10/1960 218-84-6077 47 Director 1 M 2X F Yrs Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location any 10a. State 10b. County 1 Yes 2 X No Eastpoint items 23a or 28a-f show ust be notified at once. Maryland Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21s narriced other than "natural", or items 23s or 28s-f she lajury or other trannatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21224 7324 Kirtley Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes White Specify: 1 Yes 2 X No specify: 4 X Divorced If Yes, Give Yea 3 Widowed à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Collection Company 21215-0036 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryann Barr Edward Otto Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Maryland 21222 9 2041 Kelmore Road, Baltimore, April Nieto (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place Burial 2 X Cremation 3 Removal from State Bayview Crematory, Inc. 11/10/2007 Baltimore, Maryland Other Specify 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 .21. Signature of Euro III Service Licensee Approximate Interval 23a. Part I. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death 'Medical a. Methadone and fentanvl intoxication Immediate Cause (Final disease aminer ondition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi ian/Medical XUNPENDED AMENBED 27,28a-f, perME.g875, 1/16/08 TI the attending physician ed for use as the burial the Hospital or Attending Physician; The law requires that the death certificate be 23d. Date of delivery Box 68760 IF FEMALE Fetal death Day Year 23b. Was decedent pregnant in the Ectopic pregnancy Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>о</u> 1 Yes 2 No 3 Probably 4 V Unknown ò 24b. Were autopsy findings available Completed Records, 24a. Was an peen prior to completion of cause of autopsv death? performed? certificate has b ector, page 2 sh 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical director, of Vital Be Other₄ Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 DOA Inpatient 2 ER/Outpatient 3 this ဂ္ 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification 1 Yes 2 XNo within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural Division 5 Pending FNd 11/8/2007 Fnd 10:35 and Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 7324 <u>Kirtley Rd</u> 6 X Could not be 3 Suicide Dundalk, MD determined (Specify) other scene Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 9, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

State Registrar

**OCME** 

David Fowler M.D. 31. Date filed (Month Day Year

Chief Medical Examiner

egistrar's Signature

ORIGINAL

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

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"natural"

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ray injury or other traumatic event, the Medone.

the Medical Examiner

Director

Funeral

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Completed

Be

death with the Maryland

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year O تحرار LITVAK MATVEY 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SINAL HOSPITAL BALTIMORE OF BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 **X**M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 0570671918 UKRAINE 213-43-7446 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 UKRAINE 3615 FORDS LANE, #214 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Bace · American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN HARDWARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNOBTAINABLE UNOBTAINABLE UNOBTAINABLE UNOBTAINABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 130 SLADE AVENUE, #221. BALTIMORE, MD 21208 MIKHAIL LITVAK / SON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG 11/13/2007 BALTIMORE. MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 21. Signature of Funeral Service Licensee Solv 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of): CARDIOVASCULTAR HEEDSCLELOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): FRACTURED Due to (or as a consequence of): DISEASE SEERIE CATION APPROVED BY 18 DI 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIRRILLATION 2 No 3 Probably 4 Unknown 1 ☐ Yes ONGESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? MILO DEMENTIA 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation FELL 05:33 AM 1 ☐ Yes HOME AT

Examiner Physician/Medical þ Completed Be P Certification:

Medical

is after death.
I Director: After this of in by the funeral d

IF FEMALE:

27. Manner of Death 1 Natural

2 Cccident 3 Suicide 4 Homicide

(Check only one)

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) HOME

HOSPITAL

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3615 FORDS LANE, BALTIMORE MD 21219

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

0

29c. License number ES-000

SINAL

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATJA KISELJAK VASSILIADES

31. Date filed (Month, Day, Year) NOV 1 4 2007 32. Registrar's Signature

Registrar

within 24 hours a

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ам November 13, 2007 5:00 Hugh Anthony McGarvey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Lanham 9319 Washington Boulevard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 76 July 17, 1931 Washington, Director 579-38-0507 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at ty∐Yes 2 No Director Maryland Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 20706 USA 9319 Washington Boulevard Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ★ Yes 2 □ No
If Yes, Give
Year or Dates: '51-'62 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2K Married Specify: White 1 ☐ Yes 2X No Maryland 21215-0036 Ş 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Vending 4 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill out of Health and Mental H t: If item 27 Is marked oth Ann M. Davish Aloysius Anthony McGarvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9319 Washington Boulevard Lanham, MD 20706 Mary M. McGarvey/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1X Burial 2 □ Cremation 3 □ Removal from State 6 Resurrection Cemetery Department Important: I any Injury o once. 11/16/2007 Clinton, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Emeral S 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) moul **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t irector, page 2 s death? perform 2 No Hospital or Attending Physician: after death.

Director: After this certific
I in by the funeral director, 26. Place of Death Check onl one 25. Was case referred to medical Be Other: 4 Nursing Home Schesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled ir 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 101 50-

3T1

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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DHMH 17 Rev 1/2001

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been sinned but the attendant actions about 1.1. Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Baltimore, Maryland 21215-0036

and w		10a. State 10b. County		10c. City, To	wn or Location				10d. Inside City Limits		
Marylan f ehow	ក្ត	MD		Bal	timore	more					
28a	Director	10e. Street and Number	-		10f. Zip Code		10g.	Citizen of What Co	ountry?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow my injury or other treumatic event, the Madical Examinar must be nutified at Once.	0	10 E. 21st St	reet #B			21218		USA			
death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (S	pecify Yes or No-	No- 14. Race - American Indian, Black, White, etc.			
or its	F	1 Never Married 2 ☐ Mar			1 ☐ Yes 2X No	o rican, etc.)	Specify: White				
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"nati	Completed		t's Education st grade completed)	16:	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wor	rking 16b	. Kind of Business	Industry		
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Ald be Aenta rked tic ev	To B	Joseph Mason				Sarah	Wilson				
shot sma		19a. Informant's Name/Relations	hip (Type, Print)	19	b. Mailing Address (Street	and Number or Ru	ural Route Number, Cit	ty or Town, State, 2	Zip Code)		
and 2 salth a n 27 l		William Mason/	brother	3	3025 Longvier	w Lane Fo	ort Myers,	FL 33917			
of He of He firen		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation	3 DRemoval from State	l camet	of Disposition (Name of ery, crematory or other pla	ce)	Date 20c	. Location - City or	Town, State		
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epart poort ny inj		21. Signature of Funeral Service			²² Crematic	op Societ	y Of Maryl	and Inc.	299 Frederi		
g 0 = 9 9		nens	Weller-				<del>201</del> 2122	8	Rd.		
		3a. Pa 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Physician		Immediate Cause (Final disease or condition resulting in death)	a	prugo		Minulia Minulia					
/Medical Examiner		resulting in death)	Due to (or as	a consequence	of): Careman	arter	dixase	,	unans		
	<u></u>	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Appendix Market Cause (Disease or injury that initiated events resulting in death) Last									
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endir use	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal deal	th 3 Ectopic pregnanc	·v		23d. Date of de			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	in the past 12 months?  1  Yes 2 No		at time of death	5 ☐ Other (specify) _			Month	Day Year		
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has b	nple						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of		
n: The ficate r, pag	S						1 Yes 2 ☑	No 1 ☐ Yes	2 No 4//		
sician certif rector	Be	25. Was case referred to medica examina	Hospital:		Oti	hor	ath (Check only one)		×4.		
Physical distribution	7	1 Pres 2 No 27. Manner of Death	28a. Date of Ini	ury 28b	Julpatierit 3 DOA	4   Nursing F	tome 5 Residence		cify)		
ding th. : Afte	ţ	1 ☐Natural 5 ☐ Pendii 2 ☐ Accident investi	ig (Month, Da	ay Year)	Time of 28c. Inju Wo	ırk? ]Yes 2∐No					
Attender dea	Certification:	3 Suicide 6 Could 4 Homicide determ	ined   286. Place of In	jury - At home,	farm, street, factory, office		28f. Location (Street		ural Route Number,		
s afte	Sert	4   Homicide	building, e	tc. (Specify)			City or Town, S	iaie)			
To the Hospital or Attending Physicial within 24 hours after death. To the Funeral Director: After this certi completely filled in by the funeral direction.		29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the best	of my knowled	ge, death occurred at the fi	me, date and place	e, and due to the cause	e(s) and manner a	s stated.		
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140		PV. J	nan. M	1)	Do	041514		11/8/20	0 /		
		30. Name and address of person ALMODR HE	who completed cause of $\mathcal{M} \mathcal{A} \mathcal{N} \mathcal{M} \cdot$	death (Item 23a	(Type, Pript)	St. Ba	llimar 1	40 21	201		
Sta Regist	-	31. Date filed (Month, Day, Year, NOV 1	2007 32 Regist	rar's Signature	29c. Licen DC ) (Type, Print) N · Or Cere						

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			For State Registrar		State of	Maryla			ent of F ate of I			ental Hy		000-		0 ( 0 0	1
			Decedent's Nam	ne (First, Middle,	Last)					5000		2. Date of De		2001	3	Time of Death	1
	Physicia /Medic		Esther R	Ruth McC	ormick							Month Novem	ber Day	8, 200	7 0	6:10 PM /	Л
	Examin		4a. Facility Name (	If not institution,	give street and nun	nber)		4b. C	ity, Town, o	r Location	of Death		4c.	County of Dea	ith		_
			Suburbar		al					Bethe			M	ontgome	ery		
	Funeral		5. Social Security 1		5. Sex 1 □ M 2 🔀 F	7. Age (In y	rs. <i>la</i> st birthdi Yrs	Mont	hs Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 03/23	rth ay, Year)	9. Bi	thplace o <i>untry)</i>	(State or Foreig	m
	Director		104-05-3 Usual Residence o				113	·.				03/23	7191	8 NY			_
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the	r 28a notii	irec	10e. Street and Nu						Zip Code				10g. Citi	zen of What C	ountry?	<b>)</b>	_
h with	st be	a D	10104 Ba	ldwin C	t.			2	20817-				Uni	ted St	ates	5	
<b>5-0036</b> 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show adral Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Dece Armed For	dent Ever in	U.S. 1	3. Was De	ecedent of H	fispanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi		ndian,	_
after	or Ite	Fu.		ried 2 ☐ Marrie		2 No			s 2 <b>×</b> No	Specify:		mouri, cto.,					
003	ural"; I Exa	d by	3 🗷 Widowed		Year or Da	ates:								Specify: Wh			_
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<b>21215-0036</b> d within 72 hours af	than	Completed	Elementary/Seco	ondary (0-12)	College (1-	-4or 5+) <b>2</b>		emake		u)							
<b>₽</b> ₩	Hygi other ent, t		17. Father's Name	(First, Middle, La	ıst)					18. Mothe	er's Name	(First, Middle	, Maiden	Surname)		<u>.</u>	-
<b>an</b>	ked c	To Be	Frank J	. Bishop						Ros	e Wa	ters					
Maryland	and M s mar umat	-	19a. Informant's N	lame/Relationship	o (Type. Print)		19b. M	ailing Addr	ess (Street	and Numb	er or Rura	l Route Numl	ber, City o	r Town, State,	Zip Co	de)	_
3 and 2	alth a		Linda C.	McCormi	ck/Daughte	er	10	104 B	aldwi	n Ct.	Beti	nesda,	MD 2	20817-			
ore es 1	of He		20a. Method of Dis		B □Removal from S	20b	. Place of Di	sposition (i	Name of or other place	ce)		ate lov 14		cation - City o			
<b>j</b>	ment ant: i ury o			5 Other (Spe		I I	Assump	tion	Catho	lic	2	2007	Gle	nwood,	Illi	nois	
Baltimore,	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical is once.		21. Signature of F	unerat Service Li	censee	11003	182	22. Name Rapp	and Addre	ss of Facili	ty Crema	tion Se	rvice	es			
<u> </u>	D = 60	-	Ship		man	<u>ت</u>	1		Gist A					aryland	_		
	100				omplications that can nly one cause on ea	aused the de ach line.	eath. Do not						arrest,		Ap Int	proximate erval Between iset and Death	
	iysician Medical		Immediate Cause disease or condition resulting in death)	on	_a	cong	eatie	e f	wart	toi	lur	2					
FY	kaminer		, , , , , , , , , , , , , , , , , , , ,	- 1	Due to (	or as a con-	equence of):										
62		r e	Sequentially list co	onditions,	b. — Due to (	or as a cons	equence of):								-		_
الم الم	nsit	Examiner	Cause (Disease or	erlying r injury													
),	in and	Exa	that initiated event resulting in death)	Last	CDue to (	or as a cons	equence of):								<u> </u>		-
8/37 ( <b>68760</b> , ificate be execu	physician and is the burial-transit	edical			d												
<b>68</b> %	ig phi as th	ledi	7=55.0														
けどん ///ジ <b>ords, P.O. Box (</b> requires that the death certif	been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceder		23c. If yes, outo	come pf preg irth 2 □ F		3 □Ectoni	ic pregnancy	v			:	23d. Date of de			
. E	ed fo	sicie	in the past 12 1 ☐ Yes 2	<b>⊠</b> No		ant at time of		5 ☐ Other		,				Month	Day	y Year	
P.O	l by th	Phy	9 Unknowr			-						1					
S, 5, 5	ignec be de	by	Part II. Other signi	ificant condition	s contributing to de	1 -		-	ng cause giv	en in Part I						ause of death?	
ESTHER Records,	een s	Completed	Coro	snary	ortery	2 013	CUS*					,,,	Yes 2	¥ŽINO 3∐F	robably	y 4 ∏Unknow	n
Sec law	2 0	nple										24a. Was	psv	prior to	comple	findings availab	е
<b>□</b> = =	cate l	2											ormed? 2 X No	death? 1 ☐ Ye	s 2[	] No	
Kith Kith	s certificate has b irector, page 2 s	Be	25. Was case refe examiner?		Hospital:				Oth		of Death	(Check only	one)				
or Vita	this all dir	P	1 Yes 2 27. Manner of Dea		28a. Date o	<del></del>	ER/Outpa		DOA	4 L NL				6 □Other (Sp.	ecify)		_
CARMICIE ESTATER Division or Vital Records, lor Attending Physician: The law requires t	After funer	io	1 🗷 Natural	5 Pending investigat	(Mont	h, Day Year,			28c. Injur Wor	k? Yes 2□	- 1	28d. Describe	now injur	y occurred			
ARM ision	deatl ctor: y the	icat	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be 28e. Place	of injury - At	home, farm,			.00 20		28f. Location	(Street an	d Number or F	Rural Ro	oute Number	
Sign	after Dire	Certification:	4 ☐ Homicide	determine	ed buildir	ng, etc. (Spe	ecify)	,	,,			City or To	wn, State	)	ianai i i	outo tvarribor,	
MC Hospital	inera y fille	aC	29a. Certifier	1 Certifying	Physician: To the	best of my l	knowledge, de	eath occur	red at the tir	me, date ar	nd place, a	and due to the	e cause(s)	and manner a	s state	d.	_
the Ho	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)	2  Medical Ex	kaminer: On the ba and mann	asis of exam ner stated.	ination and/o	rinvestiga	tion, in my c	opinion, dea	ath occurr	ed at the time	e, date and	d place, and du	e to the	e cause(s)	
Tot	To t	Σ	29b. Signature and	title of certifier	-				29c. Licens	e number			29d. Dat	te signed (Mor	th, Day	/, Year)	
	_		<b>P</b> §	AU C	5.0	Wilke	25		D	006	310	15		1/08/	07	7	
1	7		30. Name and add		ho completed cause	e of death (I	tem 23a) (Typ	pe, Print)		2 4	,		2 -11	in a fi	_	400 ==	_
1			31. Date filed (Mor	n D. W	IKS M	paietrario Cir	tem 23a) (Typ	Med	lical (	rentur	Dr.	Kuck	<u>cville</u>	Mel	2	.0850	_
	Sta	te	or. Date med (N/O/	mi, Day, rear)	0007	ogistiai 5 Ol	gratura	Donald	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1518 rristine November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 45. City, Town, or Location of Death Examiner Bayview Medical Centre Baltimore N/A Johns Hopkins 8. Date of Birth (Month, Day, Year)
JAN. 23,192 MARYLAND . Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** Months Days Hours 216-16-2964 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d, Inside City Limits 10b. County t be notified at 1XYes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 738 S. LINWOOD AVENUE 21224 "natural", or items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER CROWN CORK & SEAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Ment 27 Is marked traumatic e CHRISTIAN MANNING CLARA BANGERT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a LENA MANNING/ SISTER 738 S. LINWOOD AVENUE, BALTIMORE, MD. 21224 If item or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) OAK LAWN CEMETERY 11/13/07 BALTIMORE, MARYLAND ²² Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD. 21. Signature of Funeral Service Licenses 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Premona week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed?

Ves 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES - 000 - numer November 8, 2007

State Registrar Javan Miller

Eastern

Avenue Baltimore, MD 21224

30. Name and address of person who completed suse of death (Item 23a) (Type, Print)

4940

32. Registrar's Signature

Physician /Medical Examiner law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show notified at

Item 27 Is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be r

al Hygiene.

if Health and Menta Item 27 Is marked

permit. Pages 1 Department of I Important: If Ite any injury or ot

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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burial-transit attending physician for use as the buria ed by the a detached f signed by t cate has been signated by page 2 should b director,

Examiner this (

Division or Vital Records, P.O. Box 68760,

Physician:

Physician/Medical <u></u> Completed Be funeral Certification: After

spital or Attendi lours after death. neral Director: A within 24 hours a To the Funeral L

Medical

State Registrar

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗓 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stroke, Hypertension, Diabetes Mellitus 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 1 🕅 Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide 29a. Certifier 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Aruna S. Nathan, M.D.

NOV 1 4

31. Date filed (Month, Day, Year)

D0053615

11125 Rockville Pike, #208, Rockville, Maryland 20852

November 12, 2007

			For State	State of Maryland	-	artment of F				2007	3638	5
	_		Registrar  1. Decedent's Name (First, Middle, Las	<i>t</i> )	Cei	uncate of	Deam	2. Date of De		2007	3. Time of Death	J
	Physicia	an						Month Novembe	Day		T) II	1
	/Medic Examin		Lawrence Patrick  4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat			County of Death	4:50 -	_
	LAGIIIII		Suburban Hospita	1		Bethes	da			Montgom	ery	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year)	9. Birth	place (State or Foreig	n
	Director		142-24-1957	75	Yrs.			July 19	, 19	32	New Jerse	У
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits	3
	Mary -f sho	ţō	 Maryland   Montgo	mery Be	thesda	1					1 ☐ Yes 2X No	)
	h the	Director	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·	10f. Zip Code			10g. Citiz	zen of What Cou	intry?	_
	23a c ust be		4853 Cordell Ave	nue, #1122		20814				ted Sta		
	tems ter mi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was D <i>ec</i> edent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No rto Rican, etc.)	- 1	<ol> <li>Race - Amer Black, White</li> </ol>		
20	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates 1951 – 1	0.5.5	1 ☐ Yes 2 🖾 No	Specify:			Specify: W	hite	
2-003e	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	edt	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup			16b. Kir	nd of Business/I	ndustry	
<u>ე</u>	hin 72 In "na Medii	plet	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of wo d)	orking				
7	e filed within 7 al Hygiene. I other than "r vent, the Med	Completed	12	0311090 (1 10/01)	P1u	ımber	,			ion Plu	mbing	
and	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	, Maiden	Surname)		
<u>X</u>	2 should be and Mental is marked or raumatic ever	ို	Lawrence Patrick		1			ine McGu		•		_
Mar	12 sh h and 7 is m traum		19a, Informant's Name/Relationship (7			ng Address (Street						
E.	1 and 2 Health a em 27 is		Shirley Mulligan  20a. Method of Disposition	/ Wife 20b. P	4853_ lace of Dispo	Cordell A psition (Name of matory or other pla	i	Date		a MD 20		
<u></u>	ages int of t: If it		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Hemovai from State				i			•	
galtimor	permit. Pages 1. Department of He Important: If iten any Injury or oth		21. Signature of Funeral Service Licen		2	Crematorius 2. Name and Addre	ess of Facility Ro	hert A.	Primn	<u>esda, M</u> hrey Fu	aryland neral Home onsin Aven	T
ñ	Dep Imp any		MAN	M014	73  Be	thesda-C	hevy Cha Marvland	se Inc 28014-3	301 301	57 Wisc	onsin Aven	ue
K	- Oule		23a. Part1. Enter the dise e, or com shock, or heart failure. List only								Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a Renal Fail							Onset and Death Seven Day	
	/Medical		resulting in death)	Due to (or as a consequ		beven bay	J.					
	Examiner	L	Sequentially list conditions,	b. Cardiogeni		Two Weeks						
1	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ						-		
V:	cate be executed oblysician and the burial-transit	хап	that initiated events resulting in death) Last	c. Ischemic C  Due to (or as a consequ		nyopathy					12 Years	_
8/60	s be e sician buria	dical E										
200	ificate g phys as the	edic									190	_
X Q Q	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnand	2		2	23d. Date of deli	very	
	deat he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)				Month	Day Year	
J.	at the	hys	9 🗆 Unknown									_
Š,	w requires that the dibeen signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not resi	ufting in the t	inderlying cause gi	ven in Part I.				the cause of death?	m
Vital Records,	requi	Completed							165 2	_ NO 3F	obably 4 ∏Unknow	"
<u>ခို</u>	The law te has b age 2 st	nple	-					24a. Was		prior to o	topsy findings availab completion of cause of	le
<u>=</u>	. C CT	ပ်						1□ Yes	2 🔀 No	death? 1 ☐ Yes	2 🔀 No	
<b> </b>	Attending Physician: The law r death. ector: After this certificate has by the funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	FB/0. 4	-t SELECT Ot	her:	eath (Check only				_
ō	Phys r this eral dir	-: 10	1 ☐ Yes 2X No 27. Manner of Death	1 X Inpatient 2 ☐	28b. Time	IN OLI DOX	4 🗀 Nursing	Home 5 ☐ Res 28d. Describe			cify)	
0	nding f th. :: After e funera	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2∐No					
DIVISION	or Attend after death. Director: A in by the fu	ifice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (	Street an	d Number or Ru	ıral Route Number,	
5	tal or s afte al Dir ed in	Certification:	4 Tronnoide	building, etc. (Opecin	<i>y)</i>			City of 10	wii, State	·/		
	To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by			ysician: To the best of my kno niner: On the basis of examina								
	the H in 24 the F	ledical	one)	and manner stated.								
	No Hitl	Σ	29b. Signature and title of certifier	Westerman.	M.D.	29c. Licen				te signed (Mont		
)	10x1					D52	431		Nove	mber 12	, 2007	
	10.		30. Name and address of person who		, , , , ,	ŕ	D 1	Da+1	1.5 34	1 1	2_01/	
	Sta	ate.	Michael A. Wester 31. Date filed (Month, Day, Year)	man, M.D. 860 32. Fegistrar's Signa	atrite O OTQ	Georgeto	wn koad,	Betheso	ıa, M	aryland	Z=014	
			NOV 1 4 3	วกก7 เมื่อ	P. 19	CORAL S						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #10b&e&29c30 Per FH G873 Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 6:45 AM Vovaniar 10,2007 4c. County of Death ernon Mouroe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** tarkor Hospital Baltimore Bultimere If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** M 2□F Days Year) Yrs. 212-30-1936 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at show Anne Arundel 1 Yes 2 No Pasadera **Funeral Director** MD 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number 801 Woods Road r than "natural", or Items 23a or the Medical Examiner must be a 21122 U.S.A death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify Black þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Harbison Walker Elementary/Secondary (0-12) College (1-4or 5+) BrickLayer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Johnson Webster Monroe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6821 Barnett Road Baltimore, Maryland 21239 Artimus Monroe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 11/15/07 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Arvice Livenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Rant. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) letastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last serumence Examine The law requires that the death certificate be executed Due to (or as a consequence of): sician and burial-trans Division or Vital Records, P.O. Box 68760. physician Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4. AUnknown 1 ☐ Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2010 1 Limpatient 2 ER/Outpatient 3 DOA 2 s after death.

I Director: After this of in by the funeral d 28a. Date of Injury 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft.

To the Funeral DI

completely filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

NOV 1 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

Res000

29d. Date signed (Month, Day, Year)

November 102007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36387 1- Amend #2 per Phy G873 11/14/07 Jocertificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Month **Physician** 490 Llies alberine 8:00 am 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death RIDGEWAY MANOR NURSING HOME BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or For Months | Days | Hours | Min. | MARCH | 15, 1910 | MARYLAND 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Yrs. Director 216-32-3820 97 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worls in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5743 EDMONDSON AVENUE 21229 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes ANNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within 72 h al Hygiene. I **other than "nat**u 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 10 DOMESTIC permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARTIN SCHENK MARY SEIBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE NELLIES/ SON 1141 PELHAMWOOD ROAD, BALTIMORE, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ` 4 ☐Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 11/10/07 BALTIMORE, MD 21. Signature of Funeral Service Licensee & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Hypertunia Asterioscusta Comay O rucha Disease **Physician** 40 9002 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the be executed resulting in death) Last Due to (or as a consequence of): Box 68760 ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Physici P.O. | 5 Other (specify) 1 Yes 2 No the detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ deincuta 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Pailure beaut 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 Yes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Aversing Home 5 Residence 6 Other (Specify) 은 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19667 evalue Herearel 11-08-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard account 1310 2 to lie thy hory 508 Glou Bories Handard 21061 Housel disamo 7310 31. Date filed (Month, Day, Year) 32 Registrar's Signature Contraction of State 18000 NOV 0 9 2007 Registrar

07-08 John	346 Mangin Op	oku-		ase Typ	oe or F	rint in I Marvlan	Black Ind d / Depai	<mark>delible</mark> rtment	Ink. Er	n <mark>sure</mark> h and	All Co Menta	<b>pies A</b> I Hygie	Are Legi ene	ible.	200	7 2020
		1	- For State Registrar			, , , , , , , , , , , , , , , , , , ,			of Death					. No.	200	7 3638
Medi	Physicia ical Exami	in/ ner	1. Decedent's Nam John				ngin		Opokı	ı-La	rtey	ő	ate of Death Nonth ctober 27		Year	3. Time of Death 0638 hrs
			4a. Facility Name ( Johns Hopl			eet and numb	er)		4b. City, Ti		ocation of D	Death		40.00	unty of Deat	
	Funeral		5. Social Security I	lumber Unk	6. Sex		Age (In yrs. la	st birthday)	) If Unde	r 1 Year Days	If Under 2 Hours	Min.			Forei	
	Director	-	389-88-1 Usual Residence of	683	1 X M	2 F	59		Yrs.			lc	9 02	2 4	8   0	Gilalia
	w any	Ī	10a. State	10b. County				Town or Lo								10d. Inside City Limits 1 X Yes 2 No
_	ryland a-f sho	cto	MD 10e. Street and Nu		NA		B	altin	10f. Zip	Code			10	g. Citizen	of What Co	**
1000	the Ma a or 28 tiffed a	Director	973 St 2	Agnes	Ave					212	244			Gh	ana	
=	Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If time 72 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Marr	ied 2 v N		. Was Deced Armed Ford		S. 13.	Was Decede If Yes, specif	nt of Hisp y Cuban	panic Origin , Mexican, P	? (Specif Puerto Rica	y Yes or No- an, etc.)	14.	Race - Ame White, etc.	erican Indian, Black,
	fter dea		3 Widowed		1 1	Yes es, Give Year	2 X No	1	Yes 2	X No	specify:			Sp	ec <i>ify:</i> B	lack
	hours a natura Examin	ed by	15. Decedent's E						dent's Usual g most of wor					16b. Kind Cen	of Business tral	Delivery
	)36 thin 72 te. than "	Completed	Elementary/Sec 12th g:		,	College (1-4	or 5+)	I	Delive	eryn	nan				vice	
	5-0036 iled within 7 Hygiene. I other than the Medica		17. Father's Name	(First, Middle		CYLU							st, Middle, M		_	
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	Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Donation S	Other Suneral Service	Specify:	1		_	22. Name and March				13/07	Raii	uall	stown, Md_
	Derm Depa Impo	6	23a. Part I. Enter		11 ~	/			Marcn 4300_J	F/F Waba	n wes	ve,	Balt	imor	e, Mo	
	Physician /Medical		23a. Part I. Enter failure. List o	he disease, only one caus	e on each	ine.						rdiac or re	spiratory arre	est, shock	, or heart	Approximate Interval Between Onset and Death
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	3760 ificate b ig physi s the bu	n/Me	IF FEMALE: 23b. Was deceder			23c. If yes, ou	utcome of preg th	gnancy 2	Fetal death	3	Ectopic	pregnancy	y		Date of deliv Ionth	ery Day Year
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	D. Be t the de by the	Phy	Part II. Other sig					resulting in	the underlyin	g cause	given in Par	t I.				to the cause of death?
	ires that signed to be det	d by				<u>.                                    </u>								200		Probably 4 Unknown autopsy findings available
	ords aw requ as been 2 should	Completed								_			24a. Was autor perfo			to completion of cause of
	Rec The la ficate h	Sol	L	1						26 Place	e of Death (	Check onl	1 Yes	2No	1 🗸	Yes 2 No
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	Division of Vital Records, P.O. Box 68760, tallor Atending Physician: The law requires that the death certificate be extra fire cleath.  In precent, After this certificate has been signed by the attending physician left in by the funeral director, page 2 should be detached for use as the burial	n: To	27. Manner of De	ath	L	28a. Date o (Month,	of Injury Day,Year)	28b. Tim	e of Injury	1	ury at Work? Yes 2		3d. Describe	how injur	y occurred	
	Sion Attend r death. ector: by the f	catic	1 X Natural 2 Accident	In	ending vestigation	28e Place	of Injury - At h	nome, farm,	street, factor				Bf. Location (	Street and	d Number or	Rural Route Number, City
Ti	DVi italor urs after ral Dir	Certification:	3 Suicide 4 Homicide	de	ould not be etermined	(Specify)							or Town, \$	State)		
((b)	Division of Vital Records, P.O. Box 68760, To the Hospitalior A tending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	calC	29a. Certifier 1 (Check only one)	Certifying	Physician	: To the best	of my knowled	dge, death and/or inve	occurred at the stigation, in n	ne time, o ny opinio	tate and place n, death occ	ce, and du	ue to the cau he time, date	se(s) and and plac	manner as se, and due to	stated. o the cause(s)
	To (1 withi To (1 com	Medical	29b. Signature ar		at	nd manner st	ated				se number					(Month, Day, Year)
			11.	hime	The	Ma	le			O.C	.M.E.			Octo	ber 28, 2	007
	1		30. Name and ad	dress of pers			e of death (Iter		11 Penn S	treet F	Baltimore	, MD 21	1201			
U		State	01 0 1 0 1 1			200	gistrar's Signa		Seek )							
	Regis			NUVI	4 600	I State of	William of	100								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** TCHARD 2007 RNOLID NOVEMBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY IAKOMA If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1**⊠**M 2□ F 216-32-3025 17,1933 NORTH C COTOBER Director Usual Residence of Decedent Department of Health and Mantal Hygiene.
Important: If Item 27 Is marked other than "nature!" ---: 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No HYATTOVILLE PRINCE GEORGES **Funeral Director** MARYLAND 10g. Citizen of What Country? 10e. Street and Number 1).S.A. ROAL RIGGS 6500 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED TRUCKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PRITCHARD WILLIAM WINNIE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) (30N) PRITCHARD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition CREMATORY 11-13-2007 BALTIMORE, MARYLAND 1 ☐ Burial 2 💢 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) METRO 22. Name and Address of Facility

SOSEPH H. BROWN JR. FUNERAL HOME

2140 N. FULTON AVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner TICEM Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a P.0. 9∏Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen! 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate has funeral director, page 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 ☐ Yes 2 No 1 🗷 Inpatient 2 ER/Outpatient 2 After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After (Month, Day Year) Injury 5 ☐ Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide completely filled in by determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY GREENBELT MARTLAND 20770 trar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ROBERTS STANLEY 11:16 four m ben 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE HAMBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 3 - /9 - / 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours Min. 1 4M 2 □ F 202-40-7882 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 4 Yes 2 □ No Director hd 10g. Citizen of What Country? 10e. Street and Number 21225 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) Atenarca 18. Mother's Name (First, Middle, Maiden Si 17. Father's Name (First, Middle, Last) oberts 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is any Injury or other trauonce. 份. mother our nary altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 2007 21. Signatura of Funeral Pervice Licenses 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE LIVER DISERSE DUE TO PLLOHOL ABUSE 5 years **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2 □ No detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed DIABETES HECLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 2 No END STAGE BENE DISEASE 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

ivision or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) NOV 1 4 2007

strun

29b. Signature and title of certifier



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE MARYLAND 21225

29c. License number

RES000

29d. Date signed (Month, Day, Year)

NOVEMBER 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a, perFH, G908, 10729/2010, WS
State of Maryland / Department of Health and Mental Hygiene 077 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 07:50AM Rowe November 10 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days Months 1 □ M 2 🔀 F 65 213.38.9964 MD 11.26.1941 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 Yes No Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21001 710 Nottingham Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles William Rayner Stella Florella Robinette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 710 Nottingham Dr. Aberdeen, MD 21001 Raymond Rowe/husband 20a. Method of Disposition

1 ☐ Burial 2—☐ Greemation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Harford Mem. Gard, 11.14.07 | Aberdeen, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute on chronce Due to (or as a consequence of): End Stage Kidney
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 2 **N**o 1□ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show a or 28a-f show the notified at

item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b

if Health and Mental Hygiene.

permit, Pages 1
Department of H
Important; If ite
any Injury or ot

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

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Rosa

10a State

MD

Examiner sician and burial-trans physician the buria Physician/Medical as attending | signed by the a Completed by Be this c P After thi funeral Certification: within 24 hours after death.

To the Funeral Director: /
completely filled in by the f

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

ļ		examiner? 1 ☐ Yes	2	No	^	
	27	Manner of	Deat	h		

1 Natural 5 ☐ Pending 2 ☐ Accident 3 ☐ Suicide 4 Homicide

investigation 6 Could not be determined

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier Dancel Delation Med

RES-000

November 10,2007

m

State Registrar

Medical

Bonsel Gilstrap Johns 31. Date filed (Month, Day, Year) NOV 1 4 2007

36. Registrar's Signature

Hopkins Hospital 600 North Wolfe Street Boltimore, MD 21287

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frederick Roberts 10:24 a^M November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner 20 Bladen Road Baltimore Essex If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 XM 2 ☐ F 218-28-7336 76 Director 03/16/1931 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director Maryland Baltimore Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Bladen 21221 20 Funeral Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 2□№ 1949-1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: White 3℃Widowed 4 □ Divorced 1959 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Boiler Operator Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roberts Dorothy Ficher Owen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Hann - Daughter 2114 Ebbvale Road Manchester, Maryland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/15/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) Gardens of Faith Cem! 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. Essex, Maryland 21221 1407 Old Eastern Avenue Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list out differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1∐ Yes 2☑ No certificate Be 25. Was case referred to medical examiner 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) 1 TYes No MS 1 🗌 Inpatient P 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours and
To the Funeral Dir the Hospital 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ridge Rd. Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FFER M.D 32. Resstrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, AMD TIEM 5, 9, 11, 12, 15, 16a, 5, 17, 18, 19a-20c, 22, perill, (873, 11, 14/07, WS State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 3 6393 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 2007 6:13 PM M November 4, Levi Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1401 Taylor Avenue #2 Baltimore | Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Day) | Hours | Min. | B. Date of Birth (Month, Day, July 1, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 6. Sex **Funeral** 1⊠M 2□ F Months -unk 50 Director MD 216-74-3358 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a, State 10b. County item 27 is marked other then "neturel", or items 23a or 28a-1 show other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1401 Taylor Avenue #2 21234 USA Funerai 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk -un1Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer **Maintenance** unk 12 grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk and Mental i Pages 1 and 2 should be George Smith Louise Smith ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) unk Nicole Smith Daughter 2334 David Hill Ave. Baltimore, MD 21217 Health Hem 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 Burial 2 Termation 3 Removal from State 4 Donation 6 Double (Specify) in State Department of importent: if eny injury o 11-15-07 Baltimore, MD Greenmount Cen. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately considered the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction of the construction o 22. Name and Address of Facility March FH. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovasci **Physician** a arteriosclerotic lan /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate hes been signed by the attending physicien and
letely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 3/1 No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 __ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23a Certifian Medical completely (Check only one) and manner stated. within 2 To the ŧ 29d. Date signed (Month, Day, Year) 29b. Signature and atte of certifier 29c. License number 18667 horselette 1415 November 5, 2007 30. Name and address of person who completed cau in of death litem 23a) (Type, Print) Md PHILIP Militello Trimble Hill CT. Kutherville

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2007

Registrar's Signature

				Please	Type or Prin						egible.	
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			Registrar  1. Decedent's Name (	/First Middle 1:	esti	O.E.	Tillicate of I	Death	2. Date of De		007	3. Time of Death
*	Physicia		Marie An						Month NOV.	11, Day	200 ^{Year}	9:25 p M
	/Medic				ve street and number)		4b. City, Town, o	r Location of Death			ounty of Death	
7	Examin	er	Longview				Manche	ster		C	arrol	
p ens	Funeral Director	400	5. Social Security Nur 212–10–63		-	e (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 10/30	rth ay, Year) 1 / 1 9 1	9. Birth Cou Mar	place (State or Foreign ntry) cyland
	and w	-	Usual Residence of D 10a. State	Decedent 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show item 27 Is marked other than "natural", or items 2a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:				Was Decedent of H If Yes, specity Cuba 1 ☐ Yes 2X No	Race - Ameri Black, White pecify: W				
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Maryland 21215-0036	d 2 sl th an 17 Isr traur		Harry J.				2 Warpat					
	is 1 an of Heal item 2	1 1	20a. Method of Dispo	osition	<u> </u>	20b. Place of Disp	osition (Name of ematory or other pla		Date		ation - City or T	
JO L	Pages ent of nt: If i		1 XI Burial 2 □ 4 □ Donation	Cremation 3 l 5 □ Other (Spec	□Removal from State		awn Mem.		15/07	Marri	ottsvil	lle, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot	1	21. Signature of Fun		_	1	22. Name and Addre					
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ĸ,			23a. Part1. Enter the shock, or heart	e disease, or con t failure. List on	mplications that cause y one cause on each l	d the death. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
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1	/Medical Examiner		resulting in death)			a consequence of):	110	at the	2:12	and a		
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Box	The law requires that the death certificate be the last reen signed by the attending physicing ge 2 hould be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 9 ☐ Unknown	months?		2 ☐ Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey		23	3d. Date of deli Month	very Day Year
P.0	that the			cant conditions	contributing to death	out not resulting in the	underlying cause gi	ven in Part I.	23e. Dio	d tobacco us	e contribute to	the cause of death?
ds,	signe d be	l by	-	How					10	]Yes 2□	]No 3∏Pr	obably 4XUnknown
Vital Records,	w requires that t een signed k hould be dett	Completed by		. —					24a. Wa	as an	24b. Were au	topsy findings available
Rec	he lav has ge 2	Idm							l au	topsy rformed?	prior to death?	completion of cause of
a			25. Was case referr	ed to medical				26. Place of Dea			1 □ Yes	2 <b>/</b> No
<u>=</u>	sician: certific	o Be	examiner?	_	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpati	ent 3 DOA Ot		lome 5□Re		Other (Spec	cify)
0	g Physer this eral di		27. Manner of Death	1	28a. Date of In	ury 28b. Time	of 28c. Inju		28d. Describ			
ion	ath. r: After re funer	ațio	1 Natural 2 ☐ Accident	5 ☐ Pending investigati	ion	ay roar, mary		]Yes 2□No				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	200. I lace of it	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location City or 7	(Street and Town, State)	Number or Ru	ıral Route Number,
Ö	ital ol Irs aft ral Di led in			nd .			-44	ti data d -+		ha ani/	and masses -	a etatad
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)	1	Physician: To the best maminer: On the basis and manner s	of examination and/or	ain occurred at the linvestigation, in my	ume, date and place opinion, death occ	e, and due to thur urred at the time	ne, date and	place, and due	e to the cause(s)
	To the To the Comple	Me	29b. Signature and	title of certifier	NO AME		29c. Licen	se number		29d. Date	signed (Mont	h, Day, Year)

29b. Signature and title of certifier

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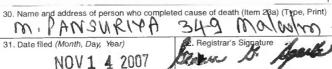
29c. License number 5 1705

29d. Date signed (Month, Day, Year) 1705 11-13-07 Westminter mp 21157

IV

State Registrar

NOV 1 4 2007



Registrar

NOV 1 4 2007

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

3altimore, Maryland 21215-0036

I Director: d in by the f within 24 hours a

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and

MEDICAL DO CTOR

RES-000

29c. License number

29d. Date signed (Month, Day, Year) November 7, 2007

30. Name and address of Arson who completed cause of death (Item 23a) (Type, Print)

ZUBERGEI JOHNS HOPKINS HOSPITML, 600 NORTH WOLFE STEERS, BACTIMORE, ND 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

cal

NOV 1 4 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08439 State of Maryland / Department of Health and Mental Hygiene Ronald Smith Certificate of Death Reg. No 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day October 30, 2007 Physician/ 0932 hrs Medical Examiner Ronald Smith 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard County General Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 1 k 6. Sex Foreign **Funeral** Months Days Hours Min. Country Director Yrs July 18. 1 X M 2 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No MD Anne Arundel Jessup 23a or 28a-f show notified at once. t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene. rtant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once irector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20794 USA 7555 Waterloo Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S unk 11 Marital Status Funera If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? unk 1 Never Married 2 Married Yes No Specify: Yes 2 X No specify: white Divorced Yes, Give Year 3 Widowed 4 호 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 unk unk 18.Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Penn Street Baltimore, O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Removal from State Burial 2 Cremation 3 Donation 5 X Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 655 W. Baltimore Street State Anatomy Board Baltimore, MD 2120 Ronald Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician fallure. List only one cause on each line 'Médical a Bilateral Pulmonary Thromboembolism Immediat Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) b. Right Lower Extremity Deep Venous Thrombosis Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED UNPENDED ned by the attending physician detached for use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 signed b Completed by

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate has Hospital or Attending Physician: 24 hours after death. Be Certification: To within 24 hours after death. To the Funeral Director: in by the f

Yes 2 No 9 Unknown	9 Unknown	5 Other (or				
art II. Other significant conditions co		esulting in the underlyi	ng cause given in Part I.		No 3 Probably	
				24a. Was an autopsy performed?	death?	findings available etion of cause of
- Maradian			26.Place of Death (Check	only one)		
E5. Was case referred to medical examiner?  1 ✓ Yes 2 No	pital: 1 Inpatient 2	ER/Outpatient 3		ng Home 5 Reside		
27. Manner of Death 1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju	ry occurred	
2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, factor	ory, office building, etc.	28f. Location (Street a or Town, State)	nd Number or Rural R	oute Number, City
4 Homicide	: To the best of my knowled on the basis of examination a	dge, death occurred at and/or investigation, in	the time, date and place, an my opinion, death occurred	d due to the cause(s) an at the time, date and pla	d manner as stated. ace, and due to the cau	use(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

unk

unk

Approximate Interval Between Onset and

Death

29d. Date signed (Month, Day, Year)

October 31, 2007

Registra DHMH 17 Rev 1/2001

29b Signature and title of certifier

31. Date filed (Month, Day, Year)

Patricia Aronica-Pollak MD.

Medical

State

**OCME 2006** 

**ORIGINAL** 

OCME

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Charles Langston Spencer 11, 2007 1:00 am M November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 281-24-7870 Director 78 11/26/1928 Ohio Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County MD Montgomery Gaithersburg 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r 109 Linden Hall Lane 20877 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XMes 2 L.No If Yes, Give Korean Year or Dates:Conflict 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier US Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William M Spencer Pearl McPherson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Thelma L. Spencer/sister 109 Linden Hall Ln. Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/14/2007 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. M01443 Ritti 933 Gist Ave, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ung Cance ears /Medical Due to (or as as sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 2 □ No 4 □Unknown certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State NOV 1 4 Registrar

V

MM ourste 3 Registrar's Signature 1200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

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Dallino	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee  M01346	22. Name and Address of FacilityRobe Rockville, Inc., 30 Rockville, Maryland			
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5	tal or rs afte	Certification:	Building, etc. (opeany)		City of Yow	n, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, d 2 ☐ Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the c red at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Montl	n, Day, Year)
	(X)		,	D08089	N	November 12	, 2007
- /	) [		30. Name and address of person who completed cause of death (Item 23a) (Tyl	1.1			
	Sta	e.	Michael Leibowitz, M.D. 11120 New Ha  31. Date filed (Month, Day, Year)  NOV 1 4 200	mpshire Ave, Ste 30	)5, Silv	er Spring,	MD 20904
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Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records,

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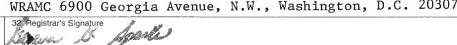
29a. Certifier

(Check only one)

29b. Signature and title of certifier

Ellen Pinholt, M.D. 31. Date filed (Month, Day, Year)

NOV 1 4



and manner stated.

Inhait MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1 🕉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0051015

29d. Date signed (Month, Day, Year)

November 13, 2007

07-08656 Larry Scott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
1-For State Amend #11 Per FH G873 1 Certificate of Death 2007 36402

Diversi		Dar	or State Transcript // 11						2 Date	of Death		3	3. Time of Death
Physic	cian/	1.	Decedent's Name (First, Midd	le,Last)					Mon	th ember	Day Y	ear	1125 hrs
√ al Exan	nine	7	Larry Sco	tt				continue of		ember	4c, Count	y of Death	
		4a	. Facility Name (if not institution	on, give street a	and number)		4b. City, Town, or L	ocation of	Deaul				
			Union Memorial Hosp				Baltimore		I	An of Pilat	N/	A Bieth	place (State or
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Yes 2  No  her:  Rural Route Number, City stated. o the cause(s)  (Month, Day, Year)

MAN T 4 TOOL Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For Amend 25,27, & 28a-f per/VE, g879 5/22/08 Tifficate of Death

Rea. No. Reg. No. 2 1 1 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 600 P M STEVENS Physician MICHAEL November 2007 /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore NorthWEST HOSPITAI Randallstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Director 220-74-9687 3-15-1956 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Reisterstown MDBaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 656 Glynlee Court 21136 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No specify: Caucasian Specify. ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Merlinone. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Steven Stevens Rose Marie Frantz 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggie Lee Medenica/Sister 5004 Klee Mill Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Metro Crematory 11-12-07 Baltimore, MD

**Physician** /Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ms 23a or 28a-f show must be notified at

r than "natural", or items the Medical Examiner mu

Examiner

siclan and burial-trans

physician s the burial

attending pl for use as t

has page 2

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

certificate be executed

Box 68760,

Records, P.O.

Division or Vital

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

Sequentially list conditions, if any, leading to in hediaticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?

☐Yes 2☐No

9 ☐ Unknown

+ F4 Natural

2 X Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Immediate Cause (Final disease or condition resulting in death)

21. Si Ature of Fundral Service Licens

23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4□Pregnant at time of death 9 Unknown

Sensis

Due to (or s a consequence of):

Dise to for as a nonsequence of

Due to (or as a consequence of)

piration

3 Ectopic pregnancy 5 ☐ Other (specify)

MELLMONIZ

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lujury

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → Hinknown

23d. Date of delivery

FURDAMI

24a. Was an autopsy performed 2 No

22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

9200 Liberty Rd., Randallstown, MD 21133

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

25. Was case referred to medical examiner? 1 X Yes 25 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work?

1 ☐ Yes 2 No

28d. Describe how injury occurred subject choked on food bolus

Nov. 4, 2007 Unk. P 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or report tory arrest shock, or heart failure. List only one cause on each line.

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 656 Glynlee Ct. Reisterstown, MD

Group Home 1 [4-extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number 65843

29d. Date signed (Month, Day, Year) November, 9, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Road, Randallstown, HD 21133

State Registrar

3

31. Date filed (Month, Day, Year) NOV1 4



			For State		State of Ma	aryland		urtment of <i>rtificate of</i>		and Me	ntal Hy	giene	007	36404
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Apr. Date	and w		Usual Residence of 10a. State	Decedent 10b. County		10c, City	, Town or Lo	cation						10d. Inside City Limits
	Maryla f shoried at	tor	Md.	NA	A		Balt							1 X Yes 2 □ No
	or 28a	Director	10e. Street and Num	nber				10f. Zip Code				10g. Citiz	zen of What C	ountry?
	ath wil	rai	633 N.	Aisquith				2120					USA	
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Division or Vital Records, P.O. Box 68760,

State Registrar

NOV 1 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Glen Alfred Taylor State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 2, 2007 **Medical Examiner** 1827 hrs GLENN ALFRED TAYLOR, JR. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2600 Brightseat Road Landover Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Director Hours Min 219 92 5859 Country) MD 1 X M 2 F 30 07/23/1976 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No items 23a or 28a-f shovust be notified at once. MD PRINCE GEORGES GREENBELT Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8565 GREENBELT ROAD #T2 20770 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. 2 X No Yes BLACK Yes 2 X No specify Widowed Divorced If Yes, Give Year Specify: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12TH WAREHOUSE WORKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GLENN ALFRED TAYLOR, SR. COSIE BENTON 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHEVELLE BOWMAN / 104 LAKEVIEW TERRACE #D GREENVILLE, NC 27834 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) T X Borlat 2 X Cremation 3 Removal from State Alexandria, VA Other Specify: Donation 5 Signature of Fineral Se 22. Name and Address of Facility MARSHALL'S FUNERAL 4308 SUITLAND ROAD HOME 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ire. List only one cause on each line Between Onset and Medical Death a. Gunshot Wound to the Back Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Co Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last executed and Physician/Medical physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? certificate ✓ Yes 2 No No To the Hospital or Attending Physician; within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this ٩ 1 V Yes 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural **FOUND** Yes 2 V No Director: d in by the f Pending Nov 2, 2007 1808 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2600 Brightseat Road, Landover , MD To the Funeral (Specify) Liquor Store 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. November 3, 2007 1 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 🕉2. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registra

OCME

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Trivilino 4:45 p м 2007 November /Medical 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Securify Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 171 -14-3814 1 □ M 2 7 F 86 Director PA June 12,1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Montgomery Rockville 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 302 Adclare Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify. þ ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce Smith McElwain Fisher Mabel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12006 Scovell Terrace, Germantown, MD 20874 19a. Informant's Name/Relationship (Type. Print) Annette Ward / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 11/14/2007 St. Mary's Cemetery 4 □ Donation 5 □ Other (Specify) New Castle, PA 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Euneral Servine License ١ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Heart Failore Conceptive **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page performed' certificate 2 No 2 **X**No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 XNo Certification: To nours after death.

neral Director: After this villed in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number
D0064624 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 83038 Gaithering, MD 20883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDEFF SHARMA PO BEX 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 1 1 7

			1 - For State of Maryland / De Registrar	partment of Health and ertificate of Death		giene 2007	36408
= = = = = = = = = = = = = = = = = = =	Physici		Decedent's Name (First, Middle, Last)     Deborah Denise Washington		2. Date of Dea		3. Time of Death 7 11:58A M
di .	/Medic Examin		4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Center	4b. City, Town, or Location of Dea		4c. County of Dea Balt:	th
بحث	Funeral Director		5. Social Security Number 217-70-1125 6. Sex 1	Months   Days   Hours   Mir		(Year) Co	thplace (State or Foreign ountry) aryland
	Maryland f show led at	or	Usual Residence of Decedent  10a. State	Location Baltimore			10d. Inside City Limits  Yes 2 □ No
	with the lag or 28a- t be notiff	Direct	10e. Street and Number 5220 Denmore Avenue Apt. 1	10f. Zip Code 21215		10g. Citizen of What Co	ountry?
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes XXNo Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.
00-6171	vithin 72 hour sne. than "natural se Medical Ex	Completed k	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	recedent's Usual Occupation live kind of work done during most of w e. DO NOT use retired) Nursing Assist		16b. Kind of Business. Convalesc	cent
land 2	vuld be filed v Mental Hygie arked other t artic event, th	To Be Co	17. Father's Name (First, Middle, Last) George Washington	18. Mother's Na	lame (First, Middle, ie Keyse	Maiden Surname)	
Mary	and 2 should leath and Men n 27 Is marke ler traumatic	-	19a. Informant's Name/Relationship (Type. Print) Suprena Harris/ Daughter-I-L 3	ailing Address <i>(Street and Number or I</i> 619 Northway Dr	Rural Route Number. Parkv	r, City or Town, State,	Zip Code) 21234
alumore,	Pages 1 and of Herint: If Item		cemetery, c	sposition (Name of crematory or other place) y Cemetery 11/	Date /15/07	20c. Location - City or Dundalk,	
Dall	permit. Departn Importa any injt		21. Signature of Funeral Service Licensee	22. Name and Address of Facility (			neral Home
e e	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	enter the mode of dying, such as cardi EL With Met			Approximate Interval Between Onset and Death Mouths
et.	/Medical Examiner	-	Due to (or as a consequence of):				
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	t the death by the atter ached for u	Physician/Me	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other ( <i>specify</i> )		Month	Day Year
ecords, r	quires that en signed b uld be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to 'es 2 □ No 3 □ P	o the cause of death?
וו שבני	To the Hospital or Attending Physician: The law requires that the death certific in thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed			24a. Was a autop perfor		utopsy findings available completion of cause of
אומו	Physician: r this certificanal director,	To Be	25. Was case referred to medical examiner?  1 Yes Parameter 1 Inpatient 2 ER/Outpar	tient 3 DOA Other: 4 Nursing	Death (Check only or Home 5 Resid	lence 6 Other (Spe	city) HOSPICE
200	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Certification:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be determined.	y Work? M 1 ☐ Yes 2 ☐ No		ow injury occurred	ural Paula Alumbar
2	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		4 Homicide determined 200. Flace of mjury Arronie, larin, building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, de		City or Tow		
	the Hos Ithin 24 ho the Fun	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/o and manner stated.  29b. Signature and title of certifier		ccurred at the time,		e to the cause(s)
)	ř »ř °°		Hendall R. Pareller				007
11.7-	3		30. Name and address of person who completed cause of death (Item 23a) (Typ Kendall R Faukor MD 555 W. Tau	soutour Blud/	Baltina	r MD	21204
	Sta Registr		31. Date filed (MNN) Vy, 1Year) 2007 32. Registrar's Signature	DENEL )			

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygiene 0 0 7 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** WALLACE 910 AM EPHUS 2007 Vovember 11. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Auchentoroly 1em 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 212-48-0341 Yrs. Director DECEMBER 20, 1948 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 2121 S. A 2906 AUCHENTOROLY TERRACE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: BLACK 3 3 Widowed 4 Divorced ges 1 and 2 should be filed within 72 hours tof Health and Mental Hygiene.

If item 27 is marked other than "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE SANITOR UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WEEMS CEPHUS LAURETTA LI PLLACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 AUCHENTORULY TERRIBALTIMORE, MD 21217 SANDRA WALLACE (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. WOODLAWN CEMETERY 11-16-2007 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2140 North FU Hop Avenue MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home Melians retrech N.h. Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPER TENSIVE LIEART DISEASE 20 YEARS /Medical Due to (or as a consequence of): Examiner HTDER TEWSLOW TEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ AMEROSCLEROSIC 1 Yes 2 No 3 Probably 4 Unknown Completed MELLITUS DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: After this certific funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2X No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Mospital of within 24 hours af To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MD NOVOMRER 13 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. MD MARTIN LINKER MD 827 LINDEN AVENUE 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar NOV 14

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d be fental Heef	Be	Gabriel Sakac	•				18. Mother's Nam		e, Maiden	Surname	*)	
should and Me mark matic	ဥ	19a. Informant's Name/Relationship		19b.	Mailing A	ddress (Street a	Mary Ku		her City o	r Town S	State Zin i	Coda)
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ie, with yielly life A 12 10 00000 stand 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	19a. Informant's Na		-		19b. Ma	ailing Addres	ss (Street					Town, State, 2	Zip Code)	
C, IVI				MS/DAUGH					ROAD,		OAK,				
) 00			☐ Cremation	3 ☐Removal fro	ill State	Ob. Place of Dis cemetery, o				Date			cation - City or		
그 등 연구		4 ☐ Donation  21. Signature of Fu				LORD RI								, BELIZE NS F.H., I	NC
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Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	art failure. List (Final on	a. A ~-	terio	nsequence of):	( '		rd to t		ſ	1	Bazo.	Approximate Interval Between Onset and Death	
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v requires that the death certificate be ey been signed by the attending physician should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1□Liv	outcome pf p re birth 2 = egnant at time known	Fetal death	3 □Ectopic 5 □ Other (		ру			2	3d. Date of del	ivery Day Year	
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tendir eath. for: Af	catio	2 ☐ Accident 3 ☐ Suicide	investion 6 Could	gation			М	1 🗆	Yes 2□N	10					
To the Hospital or Attending Physician: within 24 hours after death ownpletely filled in by the funeral director, the Funeral director and the funeral director, which is a second to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director director, the funeral director director director, the funeral director director director director, the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director	Certification:	4 □ Homicide	determ	ined 28e. Pla	ilding, etc. (S						City or Tow	vn, State)	)	ural Route Number,	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ig Physician: To t Examiner: On the and m	the best of m e basis of exa anner stated.	y knowledge, de amination and/or	eath occurre r investigation	ed at the ti	ime, date and opinion, deat	d place, and th occurred a	due to the o	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)	
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Sta Registi		31 Date filed (Mon		2007	. Registrar's	Signature	34						•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 8:00 PM NOVEMBER 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL AGNES BALTIMORE f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Months Days Hours 215 - 28 - 193 : Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any lighty or other traumatic event, the Medical Examiner must be notified of once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Completed by Funeral Director 10e. Street and Number owne 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, (Son) City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory of other place) indon Ave. Balto. MD 21229 iams Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 111 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uperal Service Licenses Z.M. 2222 W. NOTH lave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCHEMIC BOWEL Physician DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DAY ASTROTNIE Sign of all list constitutions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner DAY at the death certificate be executed and requires that the death certificate be executed after death. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the burial CAC Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated to page 2 should be 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1☐ Yes 2X No 25. Was case referred to medical examiner? director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA VILLIAM 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 SAADU AIDU SHAQ Baltimore Maryland 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar **NOV 14** 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 200^{Tea} 9 TAISTO WUORINEN 1:00Α 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frienship House Worcester Berlin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Year) XXM 2□F 93 213-07-5718 March 10,1914 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2XXVo Maryland Baltimore Harbor View 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 50th Street 21224 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XXYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes ŽŽNo Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Plumber Plumber's Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor Wuorinen Maria Wiita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald E. Wuorinen (Son) 129 Comanche Circle Millsboro, DE 19966-9011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 11/12/2007 Baltimore, Maryland 4 □ Dona β □ Other (Specify) 21. Signature uneral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each ed, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mus Due to (or as a consequence of): RILLATI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Day Year cause of death? bly 4 🗖 Unknown sy findings available pletion of cause of 2 □ No 55151 E

**Physician** /Medical Examiner

Department of h Important: If ite any injury or ot once.

**Physician** 

/Medical

Director

Funeral

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**Examiner** 

**Funeral** 

Director

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r than "natural", or items 23a or 28a-f shove the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

f Health and Mental Hygid Item 27 is marked other or other traumatic event,

Baltimore, Maryland 21215-0036

rsician and The law requires that the death certificate be executed attending physician for use as the buria as the been signed by the should be detached cate has to page 2 s the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

Examine Medical Certification: To Be Completed by Physician/Medical

	d	1									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3 □E		pregnancy (specify)			23	3d. Date of del Month	ivery Day	Year
Part II. Other significant condition	ns con	ntributing to death but not resi	ulting in the unde	erlying	g cause given in	Part I.	23e. Did tobac		se contribute to		se of deatl
							24a. Was an autopsy performe		24b. Were au prior to death? 1 □ Yes	completion	on of cause
25. Was case referred to medical					26.	Place of Dea	th (Check only one)				
examiner? 1 ☐ Yes 2 X No	Н	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆	DOA Other: 4	☐ Nursing ⊢	ome 5 Residenc	e ð	Other (Spe	cify)	55151
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigs	ation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how	injury	occurred		Ulv J.
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		28e. Place of injury - At he building, etc. (Specif.	ome, farm, stree	t, fact	ory, office		28f. Location (Stree City or Town, S	et and State)	Number or Ru	ıral Rout	te Number,
29a. Certifier (Check only one)	Phys Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death o tion and/or inve	ccurr	ed at the time, di	ate and place n, death occu	e, and due to the causurred at the time, date	se(s) a	and manner as place, and due	stated.	ause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30 Name and address of person who come leted cause of death (Item 23a) (Type, Print)

028798

FRANKLIN AVE., BERLIN, MP 21811

State Registrar

Gi 31. Date filed (Month, Day, Year) NOV 1 4 2007

32. Registrar's Signature

			State of Maryland / Department of Health and Me  1 - State Registrer Certificate of Death	ntal Hygien		36414
	Physici	an	1. Decedent's Name (First, Middle, Last) 2	Date of Death Month	ay Year	3. Time of Death
	/Medi	cal	Mary Witkowski N  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		10, 2007 c. County of Death	10:00PM
	Examir	ier	Atlantic General Hospital Berlin		Worcest	er
	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Mont	Date of Birth (Month, Day, Yea 01/29/19)	r) 9. Birth Cou	place (State or Foreign ntry) MI
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
0	r 28a-f show	tor	FL Seminole Winter Springs			1 <b>∑</b> Yes 2 □ No
220	deeth with the Maryland ms 23a or 28a-f show frount be notified at	Funeral Director	10e. Street and Number 1137 Eagles Watch Trail 10f. Zip Code 32708	10g. C	Citizen of What Cou	ntry? USA
71.19117	after or Its	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Rice of Married Status)  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 Who Specify:  1 Yes 2 Who Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White Specify:	
1/50	0 72 n	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  If John Computer Secondary (0-12)	16b.	Kind of Business/Ir	·
	filed w Hygier other th		12 Homemaker  17. Father's Name (First, Middle, Last)  18. Mother's Name (I	First, Middle, Maide		
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2 - and	ife, Marylatin Z.I.Z. s. 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumatic svent, the Mental avent, vent avent avent avent avent avent avent avent avent avent avent aven aven aven aven aven aven aven aven	-	19a. Informant's Name/Relationship (Type, Print) Mary Ann Witkowski / Daughter  19b. Mailing Address (Street and Number or Pural F			
	Dallifilore, Permit. Pages 1 ar Department of Hea mportant: If Item nny Injury or othe		20a. Method of Disposition  1 Description   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   11/14/		Location - City or Tyandotte,	
9	parinition permit. Pages 1 Department of Hi Important: If Iter any Injury or oth pice.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Charles L. Steven 1501 Fast Fort Av			C. MD 21230
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
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$ \wedge$ 0	dS, F.	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	
+Kowsk 1-3180	ACCOLOS, ne law requires to has been signer ge 2 should be	Completed		24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
30.		Be Co	25. Was case referred to medical 26. Place of Death	1 Yes 2 Check only one	No 1 ☐ Yes	2 □ No
·	~ v Ti				6 ☐ Other (Spec	ify)
371	VISION OF VITA Attending Physician: r death. sctor: After this cartific by the funeral director,	ion:	1 Natural 5 Pending (Month, Day Year) Injury Work?	3d. Describe how in	jury occurred	
	DIVISION OF OT OT Attanding Phy after death.  Director: After this in by the funeral of	Certification: To	2 Accident	Bl. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
ľ	Hospita 4 hours Fungral	Medical Co	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier  M * D  29c. License number  D 00 6 41 2 0	29d.	Date signed (Month	, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Zeeshah) Atif AGH 9733 Health way drive Berll	n M.L	2/8//	
	St Regist	ate	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of my opinion, in my opinion, death occurred at the time, date and place, and control of my opinion, in my opinion, death occurred at the time, date and place, and control of my opinion, in my opinion, death occurred at the time, date and place, and control of my opinion, in my opinion, death occurred at the time, date and place, and control of my opinion, in my opinion, death occurred at the time, date and place, and control of my opinion, in my opinion, death occurred at the time, date and place, and control of my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion, in my opinion,			

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ı	Physici		1. Decedent's Name (First, Middle, Last)	Williams					2. Date of Dea	ath 19-200=	3. Time of Death
A	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give si	reet and number)  OUN 9 09 U  T. Age (In yrs. 55)	OXTY () last bintloay) Yrs.	If Under 1	andall 1 Year If Und Days Hour	STOWN der 24 Hrs.	8. Date of Birt (Month, Da DEC 17,	y, Year) C	th Core County thplace (State or Foreign ounty)
	D .		Usual Residence of Decedent  10a, State 10b, County	10c Cit	y, Town or Loc	ration					10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow	ō									1 ☐ Yes 2 ☐ No XX
	1 the 1	rect	PA LEBANON  10e. Street and Number	LEBA	ANUN	10f. Zip (	Code			10g. Citizen of What C	
	th with	Funeral Director	533 E. CUMBERLAND STRE	ET		17	042			USA	
	r dea	ner	THE MIGHT STATES	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	.S. 13. W	Vas Decede Yes, speci	ent of Hispanic fy Cuban, Mexi	Origin? (Sp ican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Wh	
5	72 hours after neturel', or its acal Exemine	by Fu	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates:	1	☐ Yes Ž	No Spec	city:		Specify:	HITE
2-003p	2 hou		15. Decedent's Educ	ation	16a. Deced	ent's Usual	Occupation			16b. Kind of Business	
	within 7 ene. then 'n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use	k done during n e retired)	TIOST OF WORK	ing		
N	e filed within al Hygiene. I other then vent, Lie Mei		12 17. Father's Name (First, Middle, Last)		CAF	RPENTER	7	other's Nam	e /First Middle	SELF EMI Maiden Sumame)	PLOYED
yland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiens the file at 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18 and 18	o Be								maiden Samame)	
	2 should be and Mental le marked o raumatic eve	10	FREDERICK WILLIAMS  19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address			SHESSLER al Route Numbe	er, City or Town, State,	Zip Code)
Ma,	1 and 2 Health a tam 27 le		ELIZABETH A. WILLIAMS					STREET	LEBANON,	PA 17042	
more,	of He of He If itam or oth		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 XXRe	20b. F	Place of Dispos semetery, crem	sition (Nam natory or oti	e of her place)		Date	20c. Location - City o	r Town, State
	t. Pag rtment rtent: njury o		4 □ Donation 5 □ Other (Specify)	BAY	VIEW CRE				2.2007	BALTIMORE,	
g	permit. Pages 1 an Department of Heali Important: If itam 2 eny Injury or other ance.		21. Sign und Anneral Service Licence  K GREGOR FINI	MO1148	FIN 426	NAME AND NK FUNE CRAIN	RAL HOME HWY S.	P.A. GLEN BU	t/a MARYI JRNIE, MD	_AND MORTUARY 21061	SUPPORT
ũ			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that ceused the deat e cause on each line.	h. Do not ente	er the mode	of dying, such	as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	End stage	iver di	sease	2				Onset and Death
	/Medical Examiner		resulting in deputy	Due to (or as a conseq	rough	dien	ase				
ļ	pa tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a bohseq	uence of):	CVISE	use			-	
'n	physicien and sthe burial-trans	Examiner	that initiated events c.	Due to (or as a conseq	uence of):						
8/60	ate be hysicie the but	edical	€ d.								
O. BOX 6	eath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pre Other (spe				23d. Date of de Month	elivery Day Year
ı.	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	iderlying ca	use given in Pa	art I.	23e. Did t	obacco use contribute	to the cause of death?
cords,	law requires that es been signed b 2 should be deta	ted t		-					10	Yes 200 3□F	robably 4 Unknown
Ä	The lay ete hes page 2	Completed				·	=		24a. Was autor perfo 1 ☐ Yes	prior to death?	
VIII	sician: Th certificete irector, pag	Be (	25. Was case referred to medical examiner?	- anitali			- T .	lace of Deat	h (Check only o	one)	
0	Phys this raldi	7	1 Yes 2 Alo		ER/Outpatient			ursing Ho		dence 6 Other (Sp how injury occurred	ecify)
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Division	7 4 7 6	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre y)	et, factory,	, office		28f. Location (. City or To	Street and Number or F wn, State)	Rural Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical C		ician: To the best of my knower: On the basis of examination and manner stated.							
	To th To th comp	M	29b. Signature and little of certifier	- 01 A	0:		License numb			29d. Date signed (Mor	*
	£i.		Joseph /7	Dear MD.	MH	I	)0056 C	114		11-09-	2007
	B		30. Name a pladdress of person who con	mpleted cause of death (Iter	n 23a) (Type, I	Print)	Porch	) Da	12 Mahallat	men Mr	2007 ) 211 33-3521
W	Sta		31. Date filed (Month, Day Year)	2. Registrar's Signa	ature	M.	) Nucl	12	MANNE	July MIL	المحدد المالية
	Registr	rar	NOV 1 4 2007	ALEE BOOK JU'S	ALC: UNIVERSE						

			1 - For State of Maryland / Department Certification	ate of Death	Reg. 1	
	Physici		Carrend Darond da	ERRLAUT	2. Date of Death	3. Time of Death 6:30 A M
7	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. C	ity, Town, or Location of Death		4c. County of Death CARROLL
	Funeral Director		218-26-9515 1\(\frac{1}{5}\)M 2 \(\pi\)F 76 Yrs. Mont	der 1 Year   If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth (Month, Day, Yea 7 / 1 3 / 1 9 3	9. Birthplace (State or Foreign Country)  MARYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryl. f sho	ţo	MD CARROLL WESTMINST	ER		1
	r 28a	irec	10e. Street and Number 10f.	Zip Code	10g. 0	Citizen of What Country?
	th with	a D	1310 CHERRYTOWN RD.	21158		USA
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates OFFAN 1 ☐ Yes	ecedent of Hispanic Origin? (Spespecify Cuban, Mexican, Puerto s 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	72 hou natura lical E	ted	15. Decedent's Education 16a. Decedent's L (Specify only highest grade completed) (Give kind of	Jsual Occupation work done during most of worki	16b.	Kind of Business/Industry
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, Maryland	and 2 should salth and Men Men Men Men Men Men Men Men Men Men		19a, Informant's Name/Relationship (Type, Print) 19b, Mailing Addr	ress (Street and Number or Rura ERRYTOWN RD •		y or Town, State, Zip Code) ISTER, MD 21158
Baltimore,	Pages 1 and of He Int: If Item		20a. Method of Disposition  12 Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (scemetery, crematory)	Name of Crother place)	1	Location - City or Town, State
Itim	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) □ URRAINE PAR  21. Signature of Furteral Service Licensee 22. Name	and Address of Facility FT. F		BALTIMORE, MD UNERAL HOME, PA
Ba	Dep Impo					STER, MD 21157
5.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the r shock, or heart failure. List only one cause on each line.	node of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Ohset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	CA		4 Cm
	/Medical Examiner		Due to (of as a consequence of):			
	- CA	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
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O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopi 4 □ Pregnant at time of death 5 □ Other	ic pregnancy · (specify)		23d. Date of delivery Month Day Year
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ords	equire en sig ould b	ed b		<del></del>	1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	e 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al F	n: The ficate l				performed 1 Yes 2 📝	
Vital	Physician: this certificatal director,	o Be	25. Was case referred to medical examiner?  1   Yes   2   Yes   1	Other	n <i>(Check only one)</i>	e 6 □Other (Specify)
יסר	ig Phy ter this neral o	n: To			28d. Describe how in	11 //
sior	Attending r death. ector: After by the funer	atio	1	1 ☐ Yes 2 ☐ No		
Division or	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.8	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, fact building, etc. (Specity)		City or Town, St	·
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one)  1	tion, in my opinion, death occuri	red at the time, date	and place, and due to the cause(s)
	2 m 2 m	2	29b. Signature and title of certifier  Club Hull  PM	29c. License number 5 3 4 8	29d. I	Date signed (Month, Day, Year)
	Hx,		30. Name and address of person/who completed cause of death (Item 23a) (Type, Print)	Asta Street	Westerns	F MD 21157
	Sta				Jan Way	
DI	Regist	-	# 2 COO! Jackson Ja.			
יוט	117 11 17 11 EV 1/2		·			

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18 2 Year 7 **Physician** October Marcia R. Adams 11:30aM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death Examiner Holy Cross Hospital Spring If Under 24 Hrs Silver Montgomery 8. Date of Birth (Month, Day, March 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Months Days Hours 1 □ M 2 1 F Yrs. 57 1950 Director Maryland 217-52-4177 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r USA 100 Mary Lane Apt. 203 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 3€ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Office Manager Katz Insurance ages 1 and 2 should be filed vent of Health and Mental Hygie t: If Item 27 Is marked other ty or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sherman Simms Jr. ပ Matilda Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Byron Adams (Son) 7702 Jaywick Ave. Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot X Burial 2 ☐ Cremation 3 ☐ Removal from State Bestgate Mem. Park 10/24/07 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, West St. Annapolis, Md Jarry S. Buse Mc 483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Perforated Colon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Obstruction burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Metastatic Sarcoma 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐ Yes 2☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) BLVD Rakulle eath (Item 23a) (Type, Print) and address of person who completed Steren 31. Date filed (Month, Day, Year) State OCT 2 6 2007

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore.

Division or Vital Records, P.O. Box 68760,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** $\alpha 00 \neg$ /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NUCY SI H (enter Year | If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under **Funeral** Months Hours 1 ☐ M 2 🔀 F **Director** Ukn 26 Oct.8,2007 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f sh notifled 1 TYYes 2 □ No Director St. Mary's Md. Great Mills the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ıral", or items 23a or Examiner must be r 45416 Buttercup Lane 20634 United States Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or itel ury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None Mone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Jason Abney Monique Pruitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45416 Buttercup Lane Great Mills, Md. 2063 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Jason W. Abney/father 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 11/7/07 Riverdale, Md. 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 1ension /Medical Due to (or as a consequence of): Examiner neumatoce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the bunal-trans The law requires that the death certificate be executed Exami spiratery De P.O. Box 6876070 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 🕱 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be irector, page 2 s autopsy performe 1 Yes 2 100 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient မှ 2 ER/Outpatient 3 DOA s after death. I Director: After this of in by the funeral d 28a. Date of Injury 28b. Time of 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in i 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 62150

State Registrar Name and address of pe

31. Date filed (Month, Day, Year)

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ternanceo

DHMH 17 Rev 1/2001

Greene St. Baltimore MD 21201

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

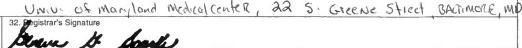
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician Month Year 10901 10 2007 10 wenya /Medical 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Ceenter NA BALTIMORE Date of Birth (Month, Day, Year) if Under 1 Year | if Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 11 M 2□F Months Days Hours 24 219-62-8458 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1-Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 900 E Royal Street 21401 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 12 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 <u>Sales Clerk</u> Hecht Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Kerwin Belt Tansey Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bens Dr. Apt. A Annapolis, Md. 21403
sposition (Name of Date 20c. Location - City or Town, State Raquel Harper (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Cemetery 10/19/07 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, P.A. West St. Annapolis, Md. 21401 Wm. 821 I. Reese MC0483 avry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) TENUMATIC BRAIN DEATH **Physician** /Medical Due to (or as a consequence of): **Examiner** 10) HRS URHICLE CRASH MOTOR REMITICATION APPROVED Sequestially not conditioned if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ospital c. 24 hours after deau.. ~ral Director: After 1 Natural 5 | Pending 1 ☐ Yes 2 🕅 No 2 Accident investigation 16-09-2007 motor vehicle crash us. Fence 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Street ANNapolis 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

within 24 hours at To the Funeral D

Registrar

Scan A. MCKAY 31. Date filed (Month, Day, Year)

OCT 2 6 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AFE 84/36

10-10-07 23:30

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 2 6 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ense thuy, Crofton, of death (Item 23a) (Type, Print) ss of person who completed cause Berez

MD

32. Pojistrar's Signature

		•	For State Registrar	State of	Maryland		artmen			and M		giene Reg. No		-7	201.2	
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212	e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or Items 23a or 28a-f show vent, the Me Kal Examiner must be notified at	Som	Elementary/Secondary (0-12)	College (1-4	2	C	lassi	fied				De	pt. of	Def	ense	
and	should be file and Mental Hy s marked oth tumatic event	To Be Completed	17. Father's Name (First, Middle, L Pleasant Lynch	ast)							<i>(First, Middle,</i> Freemar		Surname)			
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Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.		ale	ace of Dispo metery, crei			1		ate / 2007		ocation - City		State	
altir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L		Fort	Linco	DIN Co 2. Name an	d Addres	ery : is of Facilit	11/2 y For	<u>/2007  </u> t Linco	oln :	ntwood Funera	, <u>м</u> р 1 Но	me	
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9.0	Physician		23a. Pan I. Enter th disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Failure to thrive  This is a cardiac or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest, shock or respiratory arrest,										set and Death			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edwin Louis Bauerlien, Jr. 9:55 A M October 27, 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 66 Yrs. Director 212-38-2621 1941 D. C. July 23, Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Carroll 1 ☐ Yes 2 X No Maryland Finksburg Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2650 Patapsco Road 21048 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No 1958 – if Yes, Give Year or Dates: 1961 within 72 hours after 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white g 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) stone plant machine operator Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Louis Bauerlien, Sr. Lorretta Pauline Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Louise Bauerlien-wife 2650 Patapsco Road Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or ot 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 30, Sykesville, Maryland Lake View Mem. Park 4 Donation 5 Dother (Specify) 2007 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licens M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final Many **Physician** disease or condition resulting in death) wer Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown β signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 💆 Yes 2 🗆 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ate has bage 2 s autopsy performe certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO Spice 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

WIL

10-HVA

29b. Signature and title of ceptific

D.A. Rocha 31. Date filed (Month, Day, Year)

OCT 3 0

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

2007

4231

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

**ORIGINAL** 

Northwoods

29c. License number

D36112

Trail, Hampstead, MD 21074

Physician /Medical Examiner The law requires that the death certificate be executed physician and is the burial-trans Division or Vital Records, P.O. Box 68760, as

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notifled at

er than "natur, the Medical E

of Health and Mental Hygie item 27 Is marked other to other traumatic event, the

item 27 l

permit. Pages I Department of H Important: If ite any Injury or ot once.

Director

Funeral

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Completed

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed cate has l To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be ٩ Certification: Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier Jackder S MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Z

State Registrar 118 North St

Suit 3B Elken MO21921

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monti 10 26 **Physician** Clinton Tom Bullock 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1**№** M 2□F Days Hours 80 237-44-8855 Rougemont NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Director Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Brightwood Drive 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Specify: Black 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No à 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military-Armed Forces 12 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earley Bullock Estelle Parker ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Brock Bullock/Wife 8810 Brightwood Drive, Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Side Memorial 4 □ Donation 5 □ Other (Specify) Nov. 2, 07 Sumter, So.Carolina 22. Name and Address of Facility 5538 MarlboroPike, Forestville, 21. Signature of Funeral Service Licenses Maryland 20747 - Pope Funeral Homes, P.A. Part1. Enter the disease, or constructions of the shock, or heart failure. List only ications that caused ne cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) restate Corner with Metastonia to Spine Unknow Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performe 1□ Yes 2 XNo 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

permit. Pages 'Department of HIMportant: If ite any injury or ot

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

the burial-tran and attending physician cate has been signed by page 2 should be detacl After this s after death in by

or Attending Physician: The law requires that the death certificate be executed

death.

within 24 hours at To the Funeral D the Hospital

Division or Vital Records. P.O. Box 68760.

P Certification:

25. Was case referred to medical examiner? Be 1 Yes 2 No

> 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

> > (Check only one)

27. Manner of Death

5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 KER/Outpatient 3 □ DOA 28a. Date of Injury

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number D4 3446

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) October 27, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 ROINTAN FARAHIFAR

20902 Georgia Ave Suit 3-41 Silver sprin

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 3 1 2007 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 200 36426 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month Day Physician ANNBROWN OCTOBER25, 2007 /Medical 07:11A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ADVENTIST HOSPITAL WASHINGTON TAKOMA PARK MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 21K F 57 Months Days Hours 578-66-5027 Director Greenwood, Usual Residence of Decedent the Maryland ahow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic avent, the Madical Examiner must be notified at X Yes 2 No Directo Maryland Charles White Plains 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4229 Jambeau Place or items 23a 20695 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status hours after ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed with Health and Mental Hygien Item 27 is marked other th 12 Human Resource Specialist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, John Adams Mildred Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train Stephanie Brown/Daughter 4626 Grebe Place, Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If iter
any injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l.Park 4 ☐ Donation 5 ☐ Other (Specify) Nov. 3, 07 LAUREL, MARYLAND 21. Signature of Funeral Service Licenses Forestville, MD. 20747 22. Name and Address of Facility Charles E. POPE Funeral Homes, PA.5538 Marlboro Pike, 23a. Part 1. Enter the disease, or complications that day shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician herosche rotic Carangry /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Heart pertensive that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Seizure Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy to in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. cate has been sign, page 2 should be 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perforr 20 No certificate 1 Yes After this certification, J Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/OulpatienI 3□ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52326 OCTOBER 28, 2007 10 30. Name and address of person who completed thuse of death (Item 23a) (Type, Print) JAMES K. LIGHTFOOT, Jr. MD.7600 CARROLL AVE., TAKOMA PARK, MD. 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Edward Brice 1:05 $P^M$ October 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | April 22 Year) 9. Birthplace (State or ForeiMD Country) 1922 Upper Marlboro 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2 □ F 218-20-0524 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1X∏Yes 2 ☐ No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17103 Usher Place Funeral United States 20772 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 ☐ Yes 2 ⅓ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married "natural", or 1 ☐ Yes 2 ☑ No Specify. ò Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Labor Ripples Auto Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 is marked of any Injury or other traumatic ever once. Charles Brice Amanda Butler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Belt/Sister 4405 Wybille Road, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/3/07 Washington National 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signatur of Funeral Service Liorns e 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) MA Physician /Medical as a consequence of): Examiner PUMGMIQ Sequentially list conditions, if any, learning to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to for as a consequence of Examine burial-tran Due to (or as a consequence of): Physician/Medical the attending pl for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s 2 110 director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

27. Manner of Death 28b. Time of 5 ☐ Pending investigation 1 Natural Injury

Date of Injury (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

2 Accident 3☐ Suicide

4 ☐ Homicide

29a, Certifier

29c. License number Anthony Thomas, M.D.

D0046374

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 328 taem Jour

State Registrar

Medical

31. Date filed (Month, Day, Year) 0CT 3 1 2007

6 Could not be determined

**Physician** /Medical **Examiner** 

**Funeral** Director

show ä notified 28a-f 23a or r than "natural", or items 23a or the Medical Examiner must be Pages 1 and 2 should be fill ment of Health and Mental Hant: if Item 27 Is marked ott

death v

hours after

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Maryland 21215-0036

Baltimore,

Box 68760.

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Vital Records,

Division or

Physician /Medical Examiner

certificate be executed ician and burial-tran attending physician for use as the buria ed by the a has page 2 this To the Hospital or Attending the Funeral Director: After

1. Decedent's Name (First, Middle, Last) Day Regis Eugene Brennan October 26, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days **1X**□M 2□ F Yrs. 175-12-2375 88 13, 1919 \$ept. Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Tyes 2 TNo Director Maryland Prince George's Adelphi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1733 Metzerott Road 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1x Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Catholic Brother Religious Order 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Regis Eugene Brennan Mary O'Brien 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jordan Baxter/Religious 9001 New Hampshire Avenue, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 2, 4 Donation 5 Other (Specify) St. Joseph Cemetery 2007 Fort Mitchell, AL 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. Lund 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lower Gastointestinal Bleed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute on Chronic Renal Failure
Due to (or as a consequence of): Examine Hepatitis A Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyroidism 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 🗔 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Srilatha Kanumuru, MD

30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 egistrar's Signature

DHMH 17 Rev 1/2001

within 2 To the I

7300 VanDusen Road, Laurel, MD 20707

29c. License number

29d. Date signed (Month, Day, Year)

- 6

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of	Health and I	Mental Hygie	ne	
			1 - State Registrar Certificate o	f Death	Reg.	No. 2007	351,20
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month,	Day Year	3. Time of Deale
	/Medic		GEORGE A BENEDICT		October a	74 2007	00:10 M
	Examin	er	1 Mary O last Side	o, or Location of Death ふんなんし		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes	ar If Under 24 Hrs.	8. Date of Birth	9. Birthp	place (State or Foreign
	Director		217-124075 118M 20F 83 Yrs. Months Day	ys Hours Min.	(Month, Day, Ye	Court	TD
bu	>	7.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
avia	show ed at	ō				l'	1 Yes 2 No
the N	28a-f notifi	Director	MD WICO MICO SALISBURY  10e. Street and Number 10f. Zip Code	e	10g.	Citizen of What Cour	ntry?
with	3a or st be		27515 PEMBERTON 218	201		()<4	,
death	ems 2	Funeral	11. Manital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes specify C	of Hispanic Origin? (Spuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ Black, White,	
affer	or ite	y Fu	1 Never Married 2 Married 10 Yes 2 No		0 1 10011, 010.7	Specify: \ 11	11
should be filed within 72 hours after death with the Marvland	tural", al Exa	d by	3 ☐ Wildowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occ	cupation	161	o. Kind of Business/In	11th
22 0	"nat ledica	Completed	(Specify only highest grade completed) (Give kind of work dor	ne during most of wor	king		
with A	r thar	mo	Elementary/Secondary (0-12)  College (1-4or 5+)  FLORIS	7		FLOAIST :	INDUSTRY
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y ia	Ment arkec atic e	2	HERMAN GEORGE ISENEDICT	ALICE	YARKER		
<b>2</b> N	h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Stre	et and Number or Ru	ral Route Number, Ci	ity or Town, State, Zip	Code)
1 and	Healt em 2 other		BARRARA SENED ICT WIFE 27515 (HM) 20a. Method of Disposition (Name of	RERIOIN TAK	Date 200	Location - City or To	own. State
Pages 1	ent of it: If it y or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	TCDV 111-1	7-M 0	NICKUNU 1	M
Demit.			21. Signature of Funeral Service Licensee 22. Name and Ad	dress of Facility	100 J	M Gi	עני
i a	any any		Chitant respictor mooyle	K Funercy	HOME TO B	XX OI	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of o shock, or heart failure. List only one cause on each line.	lying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition  a. HYPOXEMIC RESPIRATOR	24 FAIL	URE .		Onset and Death
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s that	ned b e deta	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
aduire	en sig		MYASTHENIA GRAVIS		1 ☐ Yes	2 No 3 Prot	pably Unknown
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The	s certificate ha irector, page 2	Com			performed	death?	2□ No
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Phys	r this or	. To	T Impatient 3 DOA	Other: 4 Nursing H	ome 5 Residence	e 6 Other (Specification)	(y)
dina	h. : After	tion	1 XNatural 5 □ Pending (Month, Day Year) injury V	Vork? □ Yes 2 □ No	Edd. Boodibo ilow i	injury coodined	
Atter	r deal ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	ce		t and Number or Rura	al Route Number,
i i	s afte al Dir ed in l	Certification			City or Town, S	·	
To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	edical (	29a. Certifier (Check only 2 ☐ Medical ExamIner: On the best of my knowledge, death occurred at the 2 ☐ Medical ExamIner: On the basis of examination and/or investigation, in m	time, date and place ny opinion, death occu	e, and due to the caus	e(s) and manner as s and place, and due t	tated. o the cause(s)
the	thin 2	Medi	one) and manner stated.  29b. Signature and title of certifier 1 29c. Lice	ense number	294	Date signed (Month,	Day Year)
2	T CO	_		063199,		1.0	<u></u>
Q	dr					123/2	1
1	07		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  YUGESH VOHRA GUERSTERN SHOLE DE  31. Date filed (Month, Day, Year)  OCT 3 1 2007	SALISA	URY MD	21804	
	Sta		31. Date filed (Month, Day, Year)  32 degistrar's Signature		,		
	Registr	ar	OCT 3 1 2007 them to special				

State of Maryland / Department of Health and Mental Hygiene 200 36430 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Henry Joseph BIALOGRECK October 30, 2007 7:30 a. M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 16722 Mount Williams Circle Williamsport Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 20, 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F 92 1915 Michigan Director 047-05-6115 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 2 should be filed within 72 hours and Mental Hygiene.
and Mental Hygiene.
'Is marked other than "netural", or items 23s or 28s-f show
'Is avent, the Madical Examiner must be rediffed at 10a. State 10b. County 1 Yes 21 No Williamsport Director Washington Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16722 Mount Williams Circle 21795 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) technician aircraft mfg. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Bialogreck Albino Stephens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 ie m eny injury or other treum once. 16722 Mount Williams Cir., Williamsport, Md. 21795 Lucy Bialogreck - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park 11/3/07 Hagerstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sudden death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner arovary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 0 attending physiclen and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Schamie Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 3 Probably 4 □Unknown 1 TYes 2 No Completed 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy perform new flugron 1 Yes 2 No 25. Was case referred to medical examiner? After this certific funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funarei I

completely filled 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier was 1004113 address of person who completed cause of death (Item 23a) (Type, Print) 112ef OPAL COURT, STAGEPSTOWN , and CORPGUES 3H5+ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Ma	•	partment of F ertificate of			giene Reg. No. 2 A A	7 20121
	,sk.		Decedent's Name (First, Middle, L.)	ast)				2. Date of De	eath	3. Time of Death
	Physicia /Medic				Lee Brov				Oct 28, 2007	9:30 P M
	Examin	er	4a. Facility Name (If not institution, ga				r Location of Death		4c. County of De	
-4	Funeral			7 Dory Court Sex 7. Age	e (In yrs. last birthd	ay) If Under 1 Year	lesapeake Be If Under 24 Hrs.	8. Date of Bir	rth 9. Bi	Calvert irthplace (State or Foreign
	Director		214-50-8371	1□M 2 <b>⊠</b> F	60 Yrs	Months Days	Hours Min.	(Month, Da	23, 1947	Country) Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl I-f sho fied a	tor	MD	Calvert		CI	nesapeake B	each		1 ∐Yes 2 No
	th the or 28a e noti	)irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	s 23a	ral	6377 Dory Court	T40 W. D			20732			.S.A.
_	ter de item	Funeral Director	<ul><li>11. Marital Status</li><li>1 Never Married 2 Married</li></ul>	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔀 N	lo	<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	Black, Wh	nerican Indian, nite, etc.
22	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Memlar Hygene. f Health and Memlar Hygene. other is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: B	Black
ה ה	"natur	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	1 (G	cedent's Usual Occup ive kind of work done	during most of worl	king	16b. Kind of Business	s/Industry
7	within ene. than he Me	dmc	Elementary/Secondary (0-12)	College (1-4or 5	+) ///	e. DO NOT use retired	n Officer		Federal (	Credit Union
2	e filed Il Hygi other ent, t	Be C	17. Father's Name (First, Middle, Las					ne (First, Middle	e, Maiden Surname)	J. Guille G. Holl
2	should be filed withir and Mental Hyglene. s marked other than umatic event, the Me	To E		wn			. E	thel Ora Smith		
20	12 sho h and h 7 is ma		19a. Informant's Name/Relationship	, ,	1	ailing Address (Street	Zip Code)			
ָט ע	t and 2 Health a tem 27 is other trau		Kevin K. Brown /Son		20b. Place of Di	220 North West sposition (Name of	i	Date	FL 32606 20c. Location - City of	or Town, State
Daltillo	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			crematory or other plac ine Jones Cemet	· .	1/02/07	Chesanea	ike Beach, MD
<u> </u>	permit. Departm Importar any inju		21. Signature of Funeral Service Lice	**	Linest	22. Name and Addre	ss of Facility		Опезареа	NC DCdoll, Wib
۵	8 8 <b>8</b> 8			Servell		1451 Da	Funeral Home ares Beach R	oad Prince	Frederick, MD	
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl Immediate Cause (Final	nplications that caused y one cause on each lin	the death. Do not					Approximate Interval Between Onset and Death
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	Examiner			b.	a consequence on.					
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	rtificat ng phy as th	Medical	IE ECMAI C.							
۲ ۵	eath cer attendin for use	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mpnths?	23c. If yes, outcome   1□Live birth	2 Fetal death	3 □Ectopic pregnancy	/		23d. Date of d	lelivery Day Year
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _				,
٦,	s that ned by	by Ph	Part II. Other significant conditions	contributing to death bu	it not resulting in th	e underlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
, Oldo	equire en sig ould b							1 🗆	Yes 2XNo 3∏F	Probably 4 Unknown
נ	law r nas be	Completed						24a. Was	psy prior to	autopsy findings available o completion of cause of
<u>2</u>	n: The ficate l		05.14					1□ Yes	ormed? death? 2. No 1 ☐ Ye	
5	ysicial s certi	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2☐ No	Hospital: 1   Inpatie	nt 2 ☐ ER/Outpa	tient 3 DOA Oth	er: 4 □ Nursing He		one) idence <del>o'S</del> Other <i>(Sp</i>	necify Horpice
5	ng Ph		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Tim			·	how injury occurred	33.77
200	tendil eath. tor: A the fu	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	ho		M 1 🗆	Yes 2 □ No			
	lor At after d Direc	Certification:	4 Homicide determined		ry - At nome, tarm, c. (Specify)	street, factory, office			(Street and Number or F wn, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 120 the Luneral Director. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 1 Certifying P	Physician: To the best of	of my knowledge, d	eath occurred at the til	me, date and place	, and due to the	cause(s) and manner	as stated.
	the Ho nin 24 the Fu nplete	Medical	one)	aminer: On the basis of and manner sta				rred at the time		
	5 5 5 P	2	29b. Signature and title of certifier	, ,		29c. Licens			29d. Date signed (Mo)	nth, Day, Year)
	_		30. I ame and address of person who	o completed cause of de	eath (Item 23a) (Tvi	De, Print)	010	4	10/011	V ) -
10	W 5		Jan M. W	ilson, n	ND 47	10 Auth	1 Ylace	-395	Juitlan	elme 2014
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	Signature	1. Proces	,			
			001		M. SHITLARD & JA	AT LANGE				

		•	1 - For State Of Was Registrar		rtificate of	Death	Reg. N	0007	36432							
	Physici		1. Decedent's Name (First, Middle, Last) Milburn Alexander Buckler,	Jr.			Date of Death Month 25 20	7 Year	3. Time of Death 11:18 Ам							
Sir.	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	4	c. County of Death								
		4	Calvert Memorial Hospital		Prince F	rederick		Calvert								
	Funeral Director		5. Social Security Number  217–28–5609  Usual Residence of Decedent  7. Age	e (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	Hours Min. B.	Date of Birth (Month, Day, Yea C 17 19	9. Birth Cou Mary	place (State or Foreign ntry) / Land							
	Maryland I-f show fied at	tor	10a. State 10b. County Maryland Calvert	10c. City, Town or Lo Prince Fr					10d. Inside City Limits 1 □Yes 2 🔀 No							
	th with the 23a or 28a Ist be noti	al Director	260 Dares Wharf Road		10f. Zip Code 206	78		10g. Citizen of What Country? United States								
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1 □ Never Married 2 □ X Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces  1 □ X es 2 □ N  If Yes, Give Year or Dates:	No	Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Specify an, Mexican, Puerlo Ric Specify:	Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.							
Maryland 21215-0036	ithin 72 h ne. nan "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give life. I		oation during most of working d)	-	Kind of Business/Ir	ndustry							
7	ed w ygiel ner tl			surve	NOT.	40.14.11.11.11.15		urvey								
yland	ould be fil Mental H arked otl atlc ever	To Be	17. Father's Name (First, Middle, Last) Milburn Alexander Buckler,	Sr.		18. Mother's Name (Fi		en Surname)								
, Mar	and 2 sho salth and n 27 is ma er traum		19a. Informant's Name/Relationship (Type. Print) Mary Helen Buckler — wife	260	Dares Wha	and Number or Rural R arf Road Pr	ince Fre	or Town, State, Zi derick MI	p Code) D 20678							
Baltimore,	it. Pages 1 artment of He rtant; If item njury or other:		20a. Method of Disposition  ★☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fuperal Service Licensee	BC. DOILL	osition (Name of matory or other place Vianney ( 2. Name and Addre	on of English		Location - City or T	erick MD							
Ba	permi Depa Impo any Ir		) Brawd	44	05 Broome	es Is. Rd.	Port Rep	eral HOme ublic MD	20676							
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death)  a. Due to for as	the death. Do not ent ne.	ter the mode of digital	ng, such scardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death							
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rds, P.	The law requires that the law been signed by the las been signed by the lage 2 should be detache	þ	þ	þ	þ	þ	þ	þ	Part II. Other significant conditions contributing to death but	o death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown		
Records,	e la has je 2	Completed				<u> </u>	24a. Was an autopsy performed 1□ Yes 22	prior to co	opsy findings available ompletion of cause of							
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death (C										
<u> </u>	lis dir	To		ent 2 ER/Outpatier		4 U Nursing Home	5 Residence	6 □Other (Spec	ify)							
n o	ding P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day		Wo		. Describe how inj	jury occurred								
Division or Vital	or Atterior ter deat irector	Certification:	2 Accident investigation   M 1 Yes 2 No   3 Suicide 4 Homicide   Could not be determined   See. Place of injury - At home, farm, street, factory, office   City or Town,						ral Route Number,							
7	To the Hospital of within 24 hours all To the Funeral D completely filled	edical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best on the basis of and manner start.	f examination and/or in	th occurred at the tinvestigation, in my	me, date and place, and opinion, death occurred	due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)							
2)	<b>Го th</b> within Го th	Me	29b. Signature and title of certifier		29c. Licens	se number	29d. C	ate signed (Month	, Day, Year)							
	0		Quanto ba MAD		1304	17/53 M	DO	topol.	26. 2007							
JR IX	31		30. Name and address son who completed cause of de Eric Berg, MD 110 Hos	eath (Item 23a) (Type, pital Dr.	Print) Suite 310	) Prince Fro	ederick I	MD 20678	ne joil							
	Sta Registr		31. Date filed (Month, Day, Year) 0 CT 3 0 2007	Signature	Spelle	g.										

State of Maryland / Department of Health and Mental Hygiene, 36433 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30, october 2007 HILDA MARIE BAILEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO CO SALISBURY WICOMICO NURSING HOME If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🂢 F Director 218-20-7162 07 - 03 - 26MD Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examense thus be rediffed at 1 Yes 2 □ No Director WICOMICO SALISBURY MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 611 BOOTH STREET 21801 or Items 23a Completed by Funeral USA. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 257 No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Widowed 4 ☐ Divorced Year or Dates natural', 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) FIELD WORKER?LABORER FARMING if Health and Mental Hygitem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ETHEL PALMER 2 JAMES ROOSEVELT PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29501 DEAL ISLAND ROAD PRINCESS ANNE MD 21853 VIRGINIA MARIE WISE (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11 - 05 - 07DELMAR, DEL. ° 4 □ Donation CREMATORY OF DELMARVA eral S with Licens BENNIE SMITH FUNERAL HOME 917 W. ISABELLA ST éMed 335 MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SALISBURY, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ASCVD **Physician** resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learny to move and to move a cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. | □Yes \2 10 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Helletin 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 21 No actor. 26. Place of Death (Check only one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 12 No this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely tilled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0063199. 30. Name an dd ss of person who completed cause of death (Item 23a) (Type, Print) 614 EASTERN SHORE DR., SALISBURY, MO, 21804 YOGESH VOHRA Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 3 0 2007 Registrar

			1 - For State Registrar	State of Maryla		ent of Health ate of Deatl		lygiene Reg. No	Z U U /	36434
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	Funeral Director		5. Social Security Number 6. S	1 100.00	7			Birth Day, Year) 20 - 2	9. Birtho	place (State or Foreign ntry) Rey and
	the Marylan 28a-f show	rector	10a. State 10b. County  10b. Street and Number	seorges L	ity, Town or Location	Zip Code		100 Ci	tizen of What Cour	0d. Inside City Limits 1
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?		20774	Origin? (Specify Yes or an, Puerto Rican, etc.)	1	14. Race - Americ Black, White,	can Indian,
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Ba	permit. Departr Imports any inju	t sa	Voat f 6	7/1			<ul> <li>Annapolis</li> </ul>			, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	olications that caused the deal one cause on each line.  a	Extrer	node of dying, such a	s cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
90,	be executed siclen and burial-transit	i Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect c.  Due to (or as a consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consect consec						
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 36436 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7:05HM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 578 -07-0086 96 Feb. Director 13, 1911 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1x Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Cedar Lane 21044 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married 2 🔯 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 8 Truck Driver Food Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Samuel Iden Cochran ဂ Lulu Cordelia Kerns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Cochran - Son 12677 Folly Quarter Rd, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Nov. 3, 2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Lahrage Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed certificate ! death? 1 ☐ Yes 1∐ Yes 2□ No 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

NOV 0 1 2007

92

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License numbe

29d_Date signed (Month, Day, Year)

			1 - For State Registrar	State of Mar			of He	ealth a		ental Hyg			36	437
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Н	Funeral Director				48 Yrs.		Days	Hours	Min.	8. Date of Birth	58 ear)	Rich	nplace (State of untry) mond,	V A
			Usual Residence of Decedent			1						1.20.		
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Maryland 21215-0036	2 should by and Menta ie marked aumatic ev	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (S	Street ar	nd Number	r or Rura	l Route Numbe	r, City or	Town, State, Z	ip Code)	
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ore	0 0 == =		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name matory or othe	of er place,	,		ate	20c. Loc	ation - City or	Town, State	
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Line	nsee	55	2. Name and	Address	of Facility	, Poj	Forest	ral E	iomes,	P.A. land 20	7747
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	Physician /Medical		disease or condition resulting in death)	a. ACU	consequence of):	cardi	aı	1	n ro	er C T TOV	1			
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Box	thet the death certifica ed by the attending ph detached for use as th	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at tir		∃Ectopic preg ∃Other <i>(spec</i>						Month	,	Year
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DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day uscaden 10 Mas OCT. 27, 2007 11:00 P^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 308 TIMBERWOOD AVE. SILVER SPRING MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 ▼M 2 □ F 507-20-7763 83 JULY 12,1924 NEBŔASKA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Karyes 2 □ No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 308 TIMBERWOOD AVE. 20901 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ▼ Married 1 ☐ Yes 2 👿 No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFSET PRINTING PREP. GOV'T. PRINTING OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS SCOTT CUSCADEN NELLIE JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CUSCADEN/WIFE DONNA 308 TIMBERWOOD AVE., SILVER SPRING, MD. 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) 4 ☐ Donation CHAMBERS CREMATORY 10-29-2007 RIVERDALE, MD. 21. Signature of Funeral Service I 22. Name and Address of Eaciling
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neu monia day disease or condition resulting in death) Due tw (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Dav Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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certificate

Funeral Director: itely filled in by the

hours

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or Attending After

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it

filed withli Hygiene.

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Pages 1 Department of Important: If it any injury or o

be executed

Box 68760

Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner burial-tran attending physician for use as the buria Physician/Medical

Completed by

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

24a. Was an autopsy perform

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 No

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death

1 Natural

29a. Certifier

2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28h Time of 5 Pending investigation

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1∐ Yes

26. Place of Death (Check only one)

6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of Item 23a) (Type, Print)

110 31. Date filed (Month, Day, Year)

2007

30

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year John Joseph Creamer, III 29, 2007 9:10 /Medical October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Days **X** M 2□ F Yrs. Director 215-66-5036 51 March 15, 1956 California Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 15105 Emory Lane 20853 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ SpecifyWhite 3 ☐ Widowed 4 K Divorced th and Mental Hygiene.

I Is marked other than "natur traumatic event, the Medical. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Training Operations Support 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Creamer , Jr. Elizabeth Jane Golden 19a. Informant's Name/Relationship (Type. Print) -Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 Is
any injury or other trau
once. John Joseph Creamer, Jr. 15105 Emory Lane, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 2, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTERSTITIAL PULLVULARY 6 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown DISEASE HUPPHATROM, A Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No → ) A 24a. Was an certificate has autopsy page performed? 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1 Natural To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.0. Division or Vital Records,

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

3 0 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LIBUSE HEIMZ - MOMERLOVIC, 10605



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D005854Z

CONCORD STREET, # 500 ,

JCT JBER 29, 2007

KENSINGTON, MI)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Frances Carmine ,2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Wicomico lisbu Salisbury Rehabs Nursing C Social Security Number . Age (In yra, ast birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 415-40-3623 **Director** 3-13-1921 Tennessee Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f shov ner must be notified at Director 1 Yes 2 No MD Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Riverside Dr., Funeral Apt. A223 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Cook Wicomico County Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Grimsley Elsie Augusta Merriman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Carmine - son 4807 Goose Creek Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen_Cemetery 10-31-2007 Berlin, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart 24h-1 /Medical Due to (6) as a consequence of) Examiner ononary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by , page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check only one) Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Hofm

304343 Mt. Vernon Rd. Princess Anne, MD 21883

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0005993

29d. Date signed (Month, Day, Year)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia Medical Examir	n/ er	Decedent's Name (First, Middle,L     Larry Jerm.	aine Day	у				2. Date of Death Month October 23	Day 3, 2007	Year	3. Time of Death 2020 hrs
		4a. Facility Name (if not institution, g 1814 Metzerott Road #1				City, Town, or L .delphi	ocation of Death			ounty of Death	S
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last bir	· · -	Under 1 Year	If Under 24Hrs.	8. Date of Birth	n(MM/DD	/YYYY) 9. Birth	washington
Director		219-56-7443 1 Usual Residence of Decedent	XM 2 F	55	Yrs.	Months Days	Hours Min.	Nov.			
any		10a. State 10b. County	1	10c. City, Towr	or Location						10d. Inside City Limits
and show nce.	5	Maryland Prince	George's	Hyatts	sville						1X Yes 2 No
ith the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number  1814 Metzerott	Road		10	of. Zip Code 2078	33		•	of What Countreed State	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marri	1 AAYes 2		If Yes,	specify Cuban,	anic Origin? ( Spe Mexican, Puerto F			White, at ri	an Indian, Black, ican rican
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21215-0036 hould be filed within 72 and Mental Hygiene. is marked other than tire event, the Medical	Be Co	17. Father's Name (First, Middle, La Benjamin Day,	,			11	8.Mother's Name ( Mary Ba		laiden Su	rname)	
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Page Page ment o		4 Donation 5 Other Spec	ify:	Quant		t'1 Cer					e, Virginia
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		21. Signature of Funeral Serric Lid	tomost	M	1 4001	Bennir	of Facility Ster	NE Wasl	hine	ton, DC	Inc. 20019
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876 tificat ng ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1 Live birth		/ 2 Fetal o	leath 3	Ectopic pregnar	псу		onth Da	ay Year
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ho ho	<u>8</u>	29a. Certifier 1 Certifying Phys	ician: To the best of my ier:On the basis of exam								
To To	ĕŀ	29b. Signature and title of certifier	and manner stated.			29c. License	number		29d. Da	te signed (Mont	th, Day, Year)
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0 (2)	f	30. Name and address of person wh Tasha Greenberg MD.	o completed cause of de Assistant Medical		111 Pe	nn Street, E	Baltimore, MD	21201			
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1   Yes   20 No   3   Probably   4   Unknow   24a. Was an autopsy performed?   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   24b. Were autopsy findings available profit to completion of cause of death?   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Y	Box			23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  23c. If yes, outcome pt pr 1 Live birth 2 1	Fetal death 3		/			•
25. Was case referred to medical examiner?  1	٦.	that the			t resulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
25. Was case referred to medical examiner?  1	rds	equires en sign ould be						1 ☐ Yes	s 200 No 3□ Prot	oably 4 Unknown
25. Was case referred to medical examiner?  1	_		omplet					autopsy perform	prior to co egl? death?	mpletion of cause of
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286. Place of injury - At home, farm, street, factory, office  287. Description of the cause (s) and manner as stated.  288. Location (Street and Number or Rural Route Number, City or Town, State)  289. Certifier  (Check only)  290. Certifier  (Check only)  291. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  291. Certifier  (Check only)  292. Certifier  (Check only)  293. Certifier  (Check only)  294. Certifier  (Check only)  295. Location (Street and Number or Rural Route Number, City or Town, State)	SIOL	tendin eath. tor: Aft	catio	2 Accident investigation		M 1 🗆				
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only (Check only 2) Medical Examiner: On the cause (s) and manner as place, and due to the cause (s) and manner as stated.	2	al or At after d Direct d in by	ertifi	determined   Zoe, Flace of Injuly -	At home, farm, stre pecify)	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
and manner stated.		te Hospita 24 hours ne Funera	ledical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my one Physician (Check only one)  1 Medical Examiner: On the basis of examiner and on one physician (Check only one)	knowledge, death mination and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occu	and due to the car rred at the time, da	use(s) and manner as s te and place, and due to	tated. the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		To ti vithi To ti comp	Ĭ	29b. Signature and title of certifier				29	d. Date signed (Month,	Day, Year)
Doo 33426 October 29, 2007	(		-	30 Name and address of paragraphs are all the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of th	(Itam 22a) (Time 5		33426	C	october 29,	2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  B.LARRY JENKINS, JR., M.D. 111 LAGRANGE AVE. P.O.BOX2665 LAPLATA, MD. 20646	\ 	1379		B.LARRY JENKINS, JR., M.D. 111	LAGRANGE	AVE. P.	O.BOX2665	LAPLATA	, MD. 20646	ó
State Registrar 0CT 3 1 2007 32. Figistrar's Signature	***			31. Date filed (Month, Day, Year) 32. Figistrar's S	Signature A	rede				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 28, 2007 8:30 A Marie Dempsey 0ct /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Genesis Healthcare Spa Creek Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 4, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 □ M 2 T F 98 217**-**28**-**2042 New York Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County if item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at N☐Yes 2 No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15208 Bassford Road 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, th⊯ Medical Examiner 1 ☐ Yes 2 █No If Yes, Give 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify. Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Billing Clerk Sears 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tevas Yurgitis Barbara Jurgaiciute 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Petrakis - Daughter 15208 Bassford Road, Waldorf, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 10/31/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 2005 Physician 6 m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No P.O. ate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tyes 2 100 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Surring Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 100 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After (Month, Day Year) Injury 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Manth, Day, Year) 29b. Signature and title of dertifier 039836 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 130 (Type, Print) Due Chipe, MM 0 31. Date filed (Month, Day, State OCT 3 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1431 **Physician** 1) DWNE 10 SHIRLD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Harwood 4775 Carmody Court, Trailer D 8. Date of Birth (Month, Day, Ye Jan. 26, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Year **Funeral** Hours Months Days 1 □ M 2 🛛 F 1939 Washington, DC 68 Director 579-50-8311 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State 1 ☐ Yes 2 No Harwood r 28a-f sh notified Anne Arundel MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 20776 4775 Carmody Court, Trailer J Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Department of Health and Mental Hygiene." natural", or iten Important: If Item 27 Is marked other then "natural", or iten Important: If Item 27 Is marked other then way Injury or other traumatic event, the Medical Examiner once. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛱 No Specify. altimore, Maryland 21215-0036 Specify: white þ 3 ☐ Widowed 4 💆 Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) retail furniture clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Windsor Mary Joseph Brown Robert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4775 Carmody Ct., Trailer J, Harwood, MD 20776 Shirley A. Jones, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Chesapeake Highlands 10-29-2007 Port Republic, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licens 8325 Mt. Harmony Lane, Owings, MD ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) 114 eur **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to finned late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician the burial Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an funeral director, page 1∏ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: HUWU 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide

or Attending Physician: Director: filled In by within 24 hours after To the Funeral Dire Hospital

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) any manner stated. 29a. Certifier

29b. Signature and title of contifie

29d. Date signed (Month, Day, Year)

(C/Jyna State Registrar

Medical

445 DEFENSE HIGHWAY ANNAPOLIS M 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

30. Name and address of per-

			Pleas	se Type or F					-	_	e.
		For State Registrar		State of	Marylar		partment of F Partificate of		/lental Hyg	giene	
		Registrar  1. Decedent's Name	o (Eirot Middle	Last			er inicate or	Dealli ————	2. Date of Dea	leg. No. 20 (	7 3.3m St beat 7
. Physicia /Medic			Joseph						October		9:02 P M
Examin		4a. Facility Name (/	f not institution,	give street and num	ber)			r Location of Death		4c. County of	
	5			orial Hos				lerick	10 D 1 (D)	Freder	
Funeral Director		5. Social Security N 219–58–99		6. Sex 1 <u>x</u> M 2□ F	7. Age (In yrs $56$	last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 28	, Year)	Birthplace (State or Foreign Country) ashington, DC
PL _		Usual Residence of	f Decedent		100 0	ty. Town or	Location				10d. Inside City Limits
arylar show	Ž	10a. State	10b. County			•					1 ☐ Yes 2 No
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t Hea		20a. Method of Dis	position		20b.		position (Name of rematory or other pla		Date	20c. Location - Ci	
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mit. I		21. Signature of F			)	-	22 Name and Addre	ess of Facility De	Vol Fune	ral Home	
Pag E & S		1	ut A	Dellos			Gaithersbu	irg, MD 2	5877		
		23a Part1. Enter	the disease, or o	complications that ca	aused the dea	th. Do not e	enter the mode of dyi	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
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sit ed	Examiner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or	mmediate erlying r injury	Due to (	or as a conse	quence on:					
xecut and II-tran	хап	that initiated event resulting in death)	S	c	or as a conse	quence of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	-		-	C _d							
ficate g phy as the	Physician/Medica										
n cert	n/M	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, out	come pf pregi		3 □Ectopic pregnanc	24		23d. Date	
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To the Hospital or Atendi within 24 hours after death. To the Funeral Director: y completely filled in by the fo		29a. Certifier (Check only		g Physician: To the							ner as stated. nd due to the cause(s)
the H iin 24 the Fi	Medical	one)		and manr		action and	00-1:			account place, as	
To Too	2	29b. Signature and	d title of certifier		•		29C. Licen	ise number		29d. Date signed	(Month, Day, Year)
V		7 /	of love	w en	حك		NAN	511,10		10/23/0	) <i>f</i>
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 0325 MACH 0 26 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical Center alisbury Kimico eninsula egional If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex **Funeral** 1**X**M 2□F Days Hours Min. 6. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Yes 2 No Funeral Director ICOMICO ISBUR MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Sti Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 15 LACK ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) H5R 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BILL MAE DRENCE CAWAYON 0 NILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SBURY, MD 2/80/ 20c. Location - City or Town, State HRLETTA FITCHETT ~NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State DELMAR S OF DELMARY, SMITH F/H SALISBURY, M 21. Signature of Funeral Se 22. Name and Address of Facility ENNIE Mp 2180 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Organ **Physician** /Medical as a consequence of) Examiner Valve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the 0 9∏Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 ☐ Probably Unknowr Completed Abuse 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy After this certificate 1∐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only on examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No No Inpatient 2 ER/Outpatient 3□ DOA Certification: To Marner of Dea 1 Natural Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2∏No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign ture and

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month)

9

who completed cause of death (Item 23a) (Type, Print)

07-08442

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36449

ion Lioy	/u Diis	1.	For State Control of Dec		Reg. No.
Ph	ysicia		Decedent's Name (First, Middle, Last)  MARTON LLOYD DRISCOLL	2. Date of Month	Day Year 1415 hrs
	xamin	ıer	IMMZON	ty, Town, or Location of Death	4c. County of Death
		1	Facility Name (i) [10] [15][Idilion, give succession in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro	comoke	Worcester
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larylaı	8a-f	Director	De. Street and Number	. Zip Code 21817	U.S.A.
<b>5-0036</b> led within 72 hours after death with the Maryland	or items 23a or 28a-f show must be notified at once.		1260 Lawson Barnes Road	cedent of Hispanic Origin? ( Specify Yes	s or No- 14. Race - American Indian, Black,
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036 ithin	r than	ם	10	18.Mother's Name (First, M	
5-0 iled w	Hygie I othe		7. Father's Name (First, Middle, Last)	Rebecca Le	dford
<b>21215-0036</b> Juld be filed within 7	Mental Hygiene. marked other than "natural", ic event, the Medical Examiner	Be	Marion Elmer Driscoll  9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Add	dress (Street and Number or Rural Rou	ute Number, City or Town, State, Zip Code)
_ ~ ≥ `	and N 77 is m	To	Cheryl Lynne Smoot (Daughter) 26401 Hid	gh Banks Drive - S	alisbury, MD 21001  20c. Location - City or Town, State
<b>A</b> and 2	nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", other traumatic event, the M-dical Examiner		20a. Method of Disposition 20b. Place of Disposition	nlace)	
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Baltimore, permit. Pages l ar	9 E F		21. Sign of Funeral Se censee	e and Address of Facility shaw & Sons Funera	1 Home
<b>B</b> F	Dep inju		111111111111111111111111111111111111111	TI Maia CH = ('Y')ST	1610, MD 2101/
	sician		23a. Part I. Enter the disease, or complicate is that caused the document of the cause on each line.		Between Onset and Death
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Division of Vital Records,	after Dire	nilled in by the tune	3 Suicide 6 Could not be determined (Specify)	1	or Town, State)
Ω,	bours hours ineral		4   Homicide	ed at the time, date and place, and due t	to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760,	To the Hospital of within 24 hours all To the Funeral I	completely filled in by the function of the Con	one) Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred at the	and the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the proper
	To To	con	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Dat : 1 cm : - Hollow no	O.C.M.E.	October 31, 2007
			30. Name and address of person who completed cause of death (Item 23a)	444 Dans Circuit Deltimore A	MD 21201
4+1	EB		Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimore, M	Z IZO I
		Sta		mel.	
	Reg	iietr	NOV 0 1 2007		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Wilmia L. Epps 6:29 October 27,2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Clinton Southern Maryland Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 0.2/25/1923 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 578-34-0556 1 □ M 2 🔯 South Carolin Yrs. 84 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Upper Marlboro 1ĂYes 2□No Director Md Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 5212 Griffendale Lane USA must Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Operator Federal Govt 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilkins Julia Mitchell Garrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type. Print) (Son) Charles Epps 5212 Griffendale Lane Upper Marlboro Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Suitland Maryland 11-03-07 Cedar Hill Cemet 4 Donation 5 Dother (Specify) 20011 21. Signature Funeral Se Licensee 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW WashDC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com-shock, or beart failure. List on that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a onsequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 1 Yes 2√2 No 9 Unknown 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐Yes 2 ☐ No 25. Was cas - erred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation .ospital c. 24 hours after dea.. "reral Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital continuous afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms afforms aff 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPMD 7503 SURPATTS RD 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar/Ameno#22_PerFHPQC11-1-07cr Reg. NZ UU 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Bernet 640 PM CON OCT 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 920 H Memorial tal Havre De G Race Hartoro Harlord 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Months Days Hours NORTH CAROLINA Director 246-90-5026 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 ie marked other then "naturel", or Iteme 23a or 28e-f ehow traumatic event, trei Madical Examinar must be notified at Yes 2 □ No Director MD ABERDEEN HARFOND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21001 Sterens incle Completed by Funeral 306 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ratail Atten. 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental } Pages 1 and 2 should be Yrus 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 2/00 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Importent; If Item 27 le eny Injury or other traugnos. Stevens 16 Faulcon- Daughi er 306 Aberdee, Md ERICA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 □Removal from State Littleton NC 2 7850 7-07 Mt Olive Bapt Ch 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robinson Funeral HOME Littleton NC 27850 HW7158 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Casettand Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jau /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Cther (specify) but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 🖺 Probably Yes 2 🗆 No 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ➤ No 24a. Was an this certificete has 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 2 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Unpatient 3 DOA 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 ☐ Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hours after To the Hospital within 24 hours a To the Funerel Completely filled Centryling Physiciam: To the best of my knowledge, death occurred at the third, date and place; and due to the cause(s) and manner as stated. 29a: Curtiflar Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0036940 use of death (Item 23a) (Type, Print) HARFORD MEMORIAL HOSP (TAL, 50) UNION AVENUE, HAPPE DE CRACE 24078 *TUBZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month Physician 12:40 PM 28, Oct. L. Gordon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton 9. Birthplace (State or Foreign Country)
DC Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 🖾 F March 2, 84 1923 578-22-4438 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene.

m 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 X Yes 2 No Washington DC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 USA 30 Madison Street, NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: Black ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dept. of Commerce Patent Office Clerk traumatic event, the 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Velma Stevens Frank Richardson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other trainonce. Ft. Washington, MD 20744 208 Pelican Garth Alan Gordon/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-5-2007 Maryland National Laurel, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Euneral Service Licensee 4217 9th Street, NW Washington, DC 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac aryline /Medical Due to (or as a construence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Year Month Day ☐Yes 2₺ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🌠 No 24a. Was an autopsy performed page 2 s 2 2 No certificate 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) dire 1 ☐ Yes 2 ☑ No 1 Nnpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours area with to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State NOV 0 1 2007 Registrar

entr

Georgia Ave list 3 41 Silverspring MO 20902 9801 ROINTAN FARAHIFAR 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43446

10.29.07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elizabeth Gresham 2007 October 28, 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3008 Bonview Lane Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🗓 F 97 239-01-9083 Director Feb. 25, 1910 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3008 Bonview Lane 20906 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes **2**X If Yes, Give Year or Dates: 1 Never Married 2 Married 20X No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fand Mental F if Health and Menta Vance Mitchell Maude King ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Stephen Goodwin/Grandson 17600 Hollingsworth Drive, Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 31. permit. Pages 1 Department of H Important: If ite any Injury or ot 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. ans to 500 University Blvd. W. Silver Spring. MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or held failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Parkinsonisa Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Figure 1) that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transi and Due to (or as a consequence of): physician s the burial Physician/Medical as nding r 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 □ Ectopic pregnancy in the past 12 months? Ď 4□Pregnant at time of death 9□Unknown Month Year 5 Other (specify) ed by the a 2 😾 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' 2 XNo 2□ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No 2 ER/Outpatient 3 DOA 1 ☐ Yes P 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division or Vital Records,

To the Hospital or Attending Plantin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Medical

29a. Certifier

29b. Signature and fitte

Mark S. Rosen, MD 31. Date filed (Month, Day, Year) 30 2007



3941 Ferrara Drive, Wheaton, MD 20906

and manner stated

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D20400 29d. Date signed (Month, Day, Year)

October 29, 2007

State of Maryland / Department of Health and Mental Hygiene 17 36454 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Elizabeth Griffin 2007 8:07 Η. October 27, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 102 Hayward Ave. Fruitland Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 ☐ M 2 🖫 F 79 215-26-4266 7/6/1928 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural; or items 23a or 28a-f show any hjury or other traumatic event. The Modical Examiner man be notified at once. 1 X Yes 2 ☐ No Maryland Wicomico Fruitland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 102 Hayward Ave. 21826 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify white δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Special Education 12 Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George T. Horsman Mildred Shorter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen G. Wright/daughter 102 Hayward Ave., Fruitland, MD 21826 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Springhill Memory 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 10/31/07 Hebron, MD Gardens 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licentee 23a. Part1. Enter the disease, or complications of Paul 1 august the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caude in hard, in the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Tury years Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No nas certificate To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certifica : After this certification and funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending investigation s after decreal Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29d. Date/signed (Month, Day, Year) 29c, License number 31. Date filed (Month, Da State 2007 Registrar

Division or Vital Records, P.O. Box 68760, within 24 hours after occ.

To the Funeral Director: After

> State Registrar

Yogesh 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vohra M.D. 614 Easternshore Dr Salisbury MD 21804

29d. Date signed (Month. Dav. Year)

29c. License number

Do0 63199

			1 - For Stete Registrar	State of Maryla		artment of H			ene 2007	36456
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physic		Anna Mary Moore	Grim				November	Day Year 4, 2007	8:30 P M
	/Medi Examir		4a. Facility Name (If not institution, give :	street and number)		4b. City, Town, or	Location of Deat		4c. County of Death	
			Beverly Nursing	Center		Cumberla	ind		Allegany	7
	Funeral		5. Social Security Number 6. Sec	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day, Y	rear) Cou	place (State or Foreign ntry)
	Director		236-03-2029	]M 2√2 F	90 Yrs.			Oct. 28	1917   West	: Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary f sho	ō	MD Allegan	y La	aVale					1 ☐ Yes 2 🖔 No
	1 the	Funeral Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Cou	intry?
	h with	E D	970 National Hig	hwav		21502			USA	
	deat	ner		12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	14. Race - Amen Black, White	
99	or its		1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give	1	1 ☐ Yes 2¶ No	Specify:	,,	Specify: Whi	
21215-0036	be illed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itame 23a or 28e-f show event, the Madical Examinar must be notified at	Completed by	34 Widowed 4 □ Divorced	Year or Dates:						
<u> </u>	n 72	lete	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of wo.	rking	6b. Kind of Business/Ir	ndustry
712	iene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		retary			Church Admi	inistration
פַ	e filed withIn al Hygiene. I other than '	BeC	17. Father's Name (First, Middle, Last)			200027	18. Mother's Nar	ne (First, Middle, Ma		
ılar	should be nd Mental marked o	To B	Wesley Tasker				Nellie	(DeVault)	Tasker	
Maryland	and hand he ma	Ι.	19a. Informant's Name/Relationship (Ty			_			City or Town, State, Zi	p Code)
	and ealth m 27		Gary E. Moore	Son				, LaVale,		
Baltimore,	ges 1 it of H if ite or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval nom State		osition (Name of matory or other place	l l		Oc. Location - City or T	
ţ	t. Pa rtmen rtent: njury		'4 □Donation 5 □Other (Specify)						Cumberland	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any injury or other treumatic evonce.		21. Signature of Funeral Service Licens	nker In	2	2. Name and Addres	110		cal Service , MD 2150	
			23a. Part). Enter the disease or complishock, or heart failure. List only or	cations that caused the d	eath. Do not en			7., LaVAle or respiratory arres		Approximate
	Pnysician		Immediate Cause (Final	ne cajuse on each line.	24	19		recide	P .	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons		wyan	lan	ucal	~1	Trucks
В	Examiner		Sequentially list conditions	).						
	P =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):					
gr	and and I-trans	хаш	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	ate be executed hysicien and the burial-transit	ical E			Joque					
687	ficate p phys is the			·						
Box	leath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre					23d. Date of deliv	rery
Ď.	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>			Month	Day Year
P.0.	that the de led by the a detached t	Physician/Med	9 Unknown	9□ Unknown						
	Se us	þ	Part II. Other significant conditions con	stributing to death but not	resulting in the u	nderlying cause give	in in Part!.		cco use contribute to	
Records,	w requir been si should	Completed		abers				1 ☐ Yes	2 No 3 Pro	bably 4 □Unknown
ec	has by	nple						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	the cate ?	Con						performe 1 □ Yes 2	ed? death? No 1 ☐ Yes	2□ No
Vital	Physicien: r this certificanal director,	Be	25. Was case referred to medical examiner?	lospital:		Othe		ath (Check only one)		
ō	Phys rthis raldii	P.	1 Yes 2 No	1 Inpatient 2	ER/Outpatier 28b. Time o	I 3LIDOA	4 Schursing F	lome 5 Residen	ce 6 □Other (Speci	fy)
OU	ding th. After	tlon	1 Matural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year	) Injury	Work	:? ′es 2 □ No		,	
Division	Attendi	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A	t home, farm, str	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rur	al Route Number,
	s after s after el Direce ed in by	Certification:	4 - Hornicide	building, etc. (Spe	scily)			City of Town,	Siale)	
	Hospi 4 hour Funer ely fill		(Check only 2 Medical Examin	sician: To the best of my liner: On the basis of exam	knowledge, deat	h occurred at the tim	e, date and place	e, and due to the cau	ise(s) and manner as : e and place, and due !	stated. to the cause(s)
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (Month,	
	7 × 5 0		Dote-	lux	MO					
	,0		30. Name and address of person to co	mpleted cause of death (I	tem 22a) (Tue-	Print)	1701	//	o vember s	1000/
	10			5 /000	es Cas	ringf	on Con	I Cum	lovember 5 becland,	Md 21502
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Si	gnature			1	1	
	Registr	ar	NOV 1 1 200	7 8	15 100	Diet !				

			State of Maryland / Department #5 PerFH G874 12/03/07	artment of Health and N <i>tificate of Death</i>	lental Hygier Reg. I		36458
2	Physicia	-	1. Decedent's Name (First, Middle, Last)  Joan Burrows Hutchins		2. Date of Death Month October	25 2007	3. Time of Death 7:20 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			201 Wardour Drive	Annapolis  If Under 1 Year   If Under 24 Hrs.	0.004	Anne A	
	Funeral Director		5.16.1   6. Sex   7. Age (In yrs. last birthday)   159   16   5136   1   M 2   XF   86   Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Dec . 3 , 1920	Penns	place (State or Foreign ntry) sylvania
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	.,	-	10d. Inside City Limits
	Maryl -f sho fied a	tor	Maryland Anne Arundel	Annapolis			1X Yes 2 No
	n the r 28a	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	th wit	ral	201 Wardour Drive	21401		nited Stat	
	tems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh	nite
S O	72 ho 'natur dical	Completed	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Ir	ndustry
121	within ene. than '	dm	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home	
	filed Hygin Sther ent, th	Be Co	17. Father's Name (First, Middle, Last)	1	e (First, Middle, Maid		
<u>lan</u>	should be fand Mental s marked o	To B	James Burrows	Ca	roline Rie	es	
Maryland	2 shou and Iv Is ma			ng Address (Street and Number or Rui			p Code)
≥,	and health m 27			lardour Dr., Annap		land 214 Location - City or T	
סב	ages 1 nt of 1- : If Ite		1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State	matory or other place)		·	
Baltimore,	artme ortant Injury			e Crematory $10/2$ 2. Name and Address of Facility $J_0$		timore, M	laryiand 1 Home.Inc.
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.		Michely J. Kutta. 14	7 Duke of Glouces	ter Street	, Annapol	is, MD 2140
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
6	Physician		regulting in death)	ary disase			Onociana Boam
	/Medical Examiner		Due to (or as a cons quence of):	r			
b	RI STEET	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c				
68760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last  Due to (or as a consequence of):				
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Š	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	☐Ectopic pregnancy		23d. Date of deliv	very Day Year
P.O. Box	uires that the death certific signed by the attending p d be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 22 No 9 ☐ Unknown	□ Other (specify)		World	Day Teal
ري م	s that med b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the u		23e. Did tobacc	co use contribute to	
ğ	equire en sig ould b	ted k	diasetes, classfact chel-	2 tora/	1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
Division or Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Completed			24a. Was an autopsy performed 1 Yes 2	prior to c death?	opsy findings available ompletion of cause of
ita	clan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?		th (Check only one)		
2	Physical this call direction	은	1 ☐ Yes 25 Alo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		ome 5 Residence 28d. Describe how in		ify)
uc	ding F	ion:	Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	Zed. Describe now i	njury occurred	
/isi	Atten r death ector: by the	ficat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, str		28f. Location (Street		ral Route Number,
á	s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	iale)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  Check only one)  Addical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of Certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
			· CK W KLEMO	0418/6		10/26	101
14	MHHe.		30. Name and address of person who completed cause of death (Item 23a) (Type, Charles W. Phelps 40 135 dd	Print) Johns Iland	RD. An	napolis	10415 (M
Page 1	Sta Registi		31. Date filed (Month, Day, Year)  OCT 2 9 2007  32. Projistrar's Signature	book	, .	/	
			7				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 10 5:00 P Day28 2007 Physician Joseph W. Henry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Millersville Knollwood Manor 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 1771971 929 1 X M 2 □ F PA 77Yrs 577-38-4082 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 ☐ No Millersville Directo MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21108 899 Cecil Ave South Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖔 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Route Sales permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienc Important: if item 27 is marked other tha any fujury or other traumatic event, the 1 once. Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd Henry Mary Robinson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Glen Colter Ct., Severna Park, MD 21146 19a. Informant's Name/Relationship (Type. Print) Sheron Slack / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/1/2007 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ATHEROS CLEROTIC CARDIOVASCULAR DISEASO **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 2 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manoer of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Living Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KICBRIDE RD, BARTMORE, VID 21236 9005 WALLHCE mo 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** o ber Worre /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES DRIVE MITCHELLVILLE PEBBLE BEACH 1504 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1**₹** M 2□ F 55 Yrs 1951 Washington, D.C. 10, Nov. Director 214-60-4554 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 No MITCHELLVILLE Directo Maryland | Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20721 DRIVE BEACH PEBBLE 1504 UNITED STATES r death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) GOVERNMENT MACHINIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important; if item 27 is marked o any injury or other traumatic eve 1 and 2 should be MARIE BENETT ROSE ROBERT W. HUNDENMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DRIVE, MITCHELLVILLE, MD. 20721 1504 PEBBLE BEACH **HOLLAND-Spouse** EVELYN altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 □ Removal from State 10/30/2007 Alexandria, Virginia Parklawn Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ope Funeral Homes, F.A. 21. Signature of Funeral Service Licentee 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for selection eaguance of: Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Tyes 2 TNo 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a, Was an certificate has be irector, page 2 s autopsy 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Year (Month, Day 5 Pending investigation 1 Natural nours after death.

neral Director: A

filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled

Registrar DHMH 17 Rev 1/2001

State

30

29a. Certifier

31. Date filed

29b. Signature and title of certifier

OCT 3

Medical

1221

and manner stated

YICH MS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Monthy Day, Year)

20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 201 and per the 874 12-11-07 Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Corrine V. Hamilton October 27, 2007 10:51 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year)
Jan • 27 , 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F 578-56-8902 Director 67 1940 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ∑Yes 2 No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3010 Kidder Road 20735 United States Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2KDXNo Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: **Black** other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years Private s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) Vice President (Watkins Security Co.) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conrad Myles Cora Marshall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hamilton - Son MD 20748 Tolson Road Temple Hills, permit. Pages 1 a
Department of HeImportant: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery Nov. 3, 2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Nome, Inc. 21. Signature of Funeral Service Ligens 4001 Benning Road, NE Washington, DC 20019 23a. Part1 Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed as the burial-tran and Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: use If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day P.O. I 5 Other (specify) ☐ Yes 2 🕱 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No မှ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical vithin 24 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) LPierson and 7503 Surratts RD Clinton, MD use of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

32 Registrar's Signature

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2	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ex 7. Ag □MXXF	ge (In yrs. Ia	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da DEC . 3	y, Year)	Cou	place (State or Foreign intry) DRIDA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	I Director	10a. State 10b. County  DC  10e. Street and Number  3713 ALABAMA AVE	MILE SOUT	WAS	Town or LoSHINGT		Code 200	120				en of What Cou	Í
5-0036	nours after death ural", or items 2: Il Examiner mus	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4XXDIvorced	12. Was Decedent Armed Forces? 1 ☐ Yes XXI If Yes, Give Year or Dates:	Ever in U.S	3. 13.	I□Yes 🏋	ent of Hisify Cuba	spanic Orig n, Mexican, Specify:	jin? (Spec , Puerto F	cify Yes or No Rican, etc.)	)- 1	4. Race - Ameri Black, White Specify: BLA	ican Indian, , etc. ACK
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altimore, N	Pages 1 and nent of Health nt; If item 27 iry or other t		ARNITRA A. HODGE  20a. Method of Disposition  XXSpurial 2 Cremation 3 Company  4 Donation 5 Other (Specify	Removal from State	' I	9034 ace of Dispo emetery, crer	sition (Nam natory or ot	e of ther place	9)	Da		20c. Loc	75243 cation - City or T	
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To the l	Medical	29b. Signature and title of certifier	and manner stated			29c. Licens				Date signed (Mon	
			0			PSE	66801	<del>.</del>		10/26/7	
-(3)		30. Name and address of person who B. Patel, M.D. 7501	Surratts Rd. Cl	inton,	, Md. 2073	5 Suit	e 307				
Stat Registra	_	31. Date filed (Month, Day, Year)  OCT 2 9 2007	32. Registrar's	Signature	W						
HMH 17 Rev 1/200	)1				ORIGINA						

Physician

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

10e. Street and Number

11. Marital Status

Usual Residence of Decedent

3502 Riviera Street

1 ☐ Never Married 2 X Married

579-70-0541

10a. State

Director

Funeral

Maryland

4a. Facility Name (If not institution, give street and number)

10b. County

Southern Maryland Hospital Center

6. Sex

Prince George's

1 M 2 □ F

Louis Loyd Hedgman

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

10c. City, Town or Location

Temple Hills

7. Age (In yrs. last birthday)

55

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Clinton.

10f. Zip Code

1 □ Yes 2 ី No

20748

Months

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

2. Date of Death October 25, Day

8. Date of Birth (Month, Day, Year) 6/11/1952

4c. County of Death

10g. Citizen of What Country?

USA

Race - American Indian, Black, White, etc.

Prince George's

8:20P

9. Birthplace (State or Foreign Country)
Washington,DC

10d. Inside City Limits

1 ☐ Yes 2 No

			1 - For State Registrar	State of Maryland /	Depa <i>Cer</i>	rtment of H tificate of L	lealth and M Death	lental Hygie		36464		
	Physici		1. Decedent's Name (First, Middle, Last, Pauline G					2. Date of Death Month	Day Year			
	/Medi Examir		4e. Facility Name (If not institution, give	street and number)		C 4	Location of Death		4c. County of Dec	eth		
	Funeral	12	Coastal Hospico at 5. Social Security Number 6. Sec		oirthday)	If Under 1 Year	I Shury If Under 24 Hrs	8. Date of Birth	Q Bi	rthplace (State or Foreign		
	Director		213-24-1402	1M 2020F 76	Yrs.	Months Days	Hours Min.	01/01/31	<i>ar)</i>	rthplace (State or Foreign ountry)		
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Loc	cation				10d. Inside City Limits		
	8a-f st	ctor	VA Accomac	ek Temp	eran	ceville				1 ☐ Yes 2 ☐ No		
	with the	Funeral Director	10e. Street and Number 25441 Saxis Rd.			10f. Zip Code 2344	42	10g.	. Citizen of What C USA.	ountry?		
	ema 2	ınera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi			
39	within 72 hours after death with the Maryland ene. then "natural", or itema 23e or 28a-f ahow the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █No If Yes, Give Year or Dates:		☐Yes 2∏No	Specify:	,	Specify: B			
21215-0036	72 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done					ng 16t	b. Kind of Business	s/Industry		
121	within iene. r then	ompi	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired memaker	)		Home			
	4.2 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Med	BeC	17. Father's Name (First, Middle, Last)					(First, Middle, Mai	den Sumame)			
Maryland	d Menidit d Menimarke maric	٦	John Dennis  19a. Informant's Name/Relationship (Ty	one Print)	Dh. Mailin	Address (Street		ie Watson  ral Route Number, City or Town, State, Zip Code)				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat, or itema 23e or 28a-f show any injury or other traumatic event. The Medical Examinat must be notified at once.		Sylvia Purnell,					emperance				
Baltimore,			20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ P	temoval from State cernet	tery, crem	sition (Name of atory or other place	θ)		c. Location - City o			
ıltim	permit. Pa Departmen Important: any injury		* 4 ☐ Donation 5 ☐ Other (Specify)			mmunity  Name and Addres	Cem 11/0	3/07 <u>M</u> €	essongo,	VA		
Ba	Depar Import any ir		muy (1:	( Day ( f.	Co	oper & H	umbles Fu	neral Co.		c, VA		
			23a. Part. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	cations that caused the death. Do ne cause on each line.	not ente	r the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		c LIV	FIR CH	RCINON	uA			
æ	Examiner		Sequentially list conditions,	Due to (or as a consequence								
	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
, 00,												
68760,	ficate by physic is the b	edicai		j								
Вох	ath certifi attending p for use as		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy						23d. Date of de	. ,		
P.O. E	that the dea ed by the at detached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ANO 9 ☐ Unknown			Month	Day Year					
	signed by d be detac	by Pr	Part II. Other significant conditions cor	ntributing to death but not resulting	in the un	derlying cause give	en in Part I.	23e. Did tobac	~	to the cause of death?		
Records,	w require been si should b						1 Yes 25 No 3 Probably 4 Un					
Rec	The law te has age 2 s	Completed						24a. Was an autopsy performed	death?			
Vital	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	ĭNo 1 ☐ Ye	s 200-110		
of \	Physi r this c ral dire	. To	1 Yes 24 0	lospital: 1 Inpatient 2 EP/C  28a. Date of Injury 28b.	Outpatient . Time of	3□ DOA Othe	4 U Nursing Ho	4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
ion	r Attending Phy ler death. irector: After this i by the funeral d	ation	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  Work?  1   Yes 2   No									
Division	I or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or Attending Physician: while 24 houss falter death. To the Funeral Director: After this certification to the Funeral director, completely filled in by the funeral director,		(Check only 12   Medical Examin	alcian: To the best of my knowledger: On the basis of examination a	ge, doath and/or inv	occurred at the time	re, date and place, opinion, death occurr	and due to the caus	e(s) and manner a and place, and du	s stated. e to the cause(s)		
	o the	Medical	29b. Signature and Atte of certifier	and manner stated.		29c. License			Date signed (Mon			
	C > F 0		· /			000	58416		0-27-	-0)		
1	3A. O		30. Name and address of person who co		22000		o store	727	4.108.00.01			
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	7705		1	753 31	712 300	your Mest		
	Registr	ar	OCT 3 1 20	07 Reach 18	de	and)						

DHMH 17 Rev 1/2001

ORIGINAL

07-08403 Harry Hilghman

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day 2015 hrs October 28, 2007 Medical Examiner Harry Hilghman Wayne 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Penninsula Regional Medical Center Salisbury If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (in yrs. last birthday) If Under 1 Year Social Security Number 6. Sex **Funeral** Foreian Months Days Hours Min 51 CoMaryland Director 216-70-6934 12/22/1955 Yrs 1 X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County è 1 X Yes 2 No 28a-f show s 23a or 28a-f shov e notified at once. Maryland Wicomico Fruitland 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 338 Holiday Street 21826 USA 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 27 is marked other than "natural", or items umatic event, the Medical Examiner must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 X No utimore, MD 21215-0036

ut. Pages I and 2 should be filed within 72 hours after deartment of Health and Mental Hygiene. Yes white Specify: If Yes, Give Year Yes 2 X No specify: Widowed Divorced ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 maintenance restaurant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Thomas Hilghman, Jr. Esther Lee McCann 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD 4005 Meadow Bridge Rd., Salisbury, MD 21804

f Date | 20c. Location - City or Town, State Esther L. McCann/mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Wicomico Memorial Park 11/1/07 Salisbury, MD Donation 5 Other Specify: Ħ HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee CFSP Chompon  $\alpha \Lambda R \dot{\alpha}$ Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial -Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death Live birth past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions ≥ Yes 2 V No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available certificate has been sector, page 2 should 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes page ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medica Be Other₄ examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 this No 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Pedestrian struck by auto Certification: Oct 28, 2007 1943 hrs Natural 1 Yes 2 ✔ No Pending death. the Director: 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 3 6 Could not be Suicide or Town, State) US Rt. 13 NB S. of Cedar Lane, Fruitland, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie October 29, 2007 O.C.M.E. Mas. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Moeth Day, Year) 2007 gistrar's Signature State Colum Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** David Todd Hertz 2007 10:00 PM 11 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25464 Military Rd. Lot 10 Washington County Cascade 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 176-50-1211 Director 42 04-17-65 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show if than "natural", or Items 23a or 28a-f share the Medical Examiner must be notified 1 ¥ Yes 2 No Director M D Washington Co. | Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 25464 Military Road 21719 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Concrete Finisher Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, ti once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Hertz ဂ Donna Hetrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 881 Cascade, Maryland 21719
e of Disposition (Name of Date Date 20c. Location - City or Town, State <u>Donna H. Tyler/mother</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfield Union Cem. 11-5-07 Fairfield, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. L. Davis Funeral Home Smithsburg, 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroselecot. 2 (01010M /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Liver Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? Yes 25 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dmomo

Koth

NOV 1 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Street

00056965

ARGENSTUN,

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Ma	aryland				ealth ar Death	nd Me		iene	2007	36467
	Physici /Medio		1. Decedent's Name (First, Middle, La Ronald LaVo		3						2. Date of Deat Month October	Day	2007	3. Time of Death 11:55 AM
	Examir	er	4a. Facility Name (If not institution, give street and number) 20653 Mt. Aetna Road					4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington County		
Ĭ.	Funeral Director		5. Social Security Number 6. S 217-30-6213 Usual Residence of Decedent	st birthday) Yrs.	Hagerstown  If Under 1 Year   If Under 24 Hrs.   8. Date of Birth Months   Days   Hours   Min.   (Month, Day, Year August   12					12 1	9. Birthplace (State or Foreign Country) 2 1933 Maryland			
	Maryland a-f show	ctor	10a. State 10b. County	ington	10c. City,	Town or Lo	ersto	wn						10d. Inside City Limits 1 ☐ Yes 【☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 20653 Mt. Aetna	Road			10f. Zi	p Code	21742		10	Og. Citizo	en of What Cou	•
036	within 72 hours after death with the Maryland ene. Then "netural", or iteme 23e or 28e-f ehow the Medical Examinar must be multied at	Þ	11. Marital Status 1 □ Never Married 2(X) Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:		08/53	Was Dece f Yes, spe 1  Yes		spanic Origir n, Mexican, I Specify:	n? (Spec Puerto R	ify Yes or No- ican, etc.)		4. Race - Ameri Black, White, Specify: Wh	etc.
Maryland 21215-0036	d within 72 h glene. or then "netu Ire Medica	To Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ducation de completed) College (1-4or 5		life. L	DO NOT L	ise retired	ation fu <i>ring most</i> o airman		9		d of Business/Ir abinet (	·
yland	ould be file Mental Hygarked othe		17. Father's Name (First, Middle, Last) Lewis E. Irving							Mary	First, Middle, M E. Gre	en ]	rving	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By sinch and the marked other than "natural; or Iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.		19a. Informant's Name/Relationship (  Mary O. Irving -  20a. Method of Disposition  1 \( \text{M} \) Burial 2 \( \text{Cremation} \) 3	- wife			553 M sition (Na natory or i	t. Acome of other place	etna R	oad Da	Hagerst	OWN	ation - City or To	nd 21742
Baltir	permit. P Departme Importan any injuri		4 Donation 5 Other (Specification of Funeral Service Licentary)		Dear	22	. Name a	nd Addres	s of Facility	Dou	glas Ā.	Fίε	ery Fune	eral Home Land 21742
	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lin	the death. e.	Do not ente	er the mod	de of dying	g, such as ca	ardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical Examiner	-		b. Due to (or as a	conseque									<i>y</i>
	sate be executed hysician and the burial-transit	cal Examiner	Sequentially list conditions, * any, least to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):											
	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1) JEWO DITID 2   JE etal death 3   JEctopic pregnancy							d. Date of delive Month	ery Day Year		
rds, P	w requires thet been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to									he cause of death?		
al Records,	icien: The law re certificete hes be rector, page 2 sho	To Be Completed								_	24a. Was an autopsy perform	,	24b. Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mpfetion of cause of
	rsician: Th		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 FR/Outpatient 2 FR/Out										
Division of Vital	or Attending P titer death. Director: After t in by the funera		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	1 Inpatient 2 EN/Outpatient 3 DOA				28c. fnjury at Work? 28d. Describe how in						
DIVIS		Certification;	3 Suicide 6 Coufd not be determined	building, etc.	. (Specify)	/ - At home, farm, street, factory, office (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ne Hospitel n 24 hours a ne Funeral I	Medical	29a. Certifier  (Check only one)  1 Certifying Physical Exemption (Check only one)	ysician: To the best o liner: On the basis of and manner stat	examination	edge, death n and/or inv	occurred estigation	at the time , in my op	e, date and p inion, death	place, an occurred	d due to the call at the time, da	use(s) a te and p	nd manner as s lace, and due to	tated. o the cause(s)
	To the twithin 2. To the figure complete	W	29b. Signature and title of certifier				29c. License number 29			29d. Date signed (Month, Day, Year)				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								107			
4	1-5+1 Sta	20-	Robert Gueden. 31. Date filed (Month, Day, Year)	21 32. Registra	r's Signatur	and	Dr.	Ke	edysv	alle	, mD	_2	17.56	
	Registra		NOV 0 2 2	2007	and the	9 1	Ser B	11						

			1 - For State Registrar	State of Mar	•		nent of H cate of L		_	giene Reg. No	1007	36468	
	Physici /Medio		Decedent's Name (First, Middle, Last)     RALPH LEE	JOHNSON					2. Date of De Month OCTOBE	Day		3. Time of Death	
	Examir		4a. Facility Name (If not institution, give s				-	Location of Dea			County of Death		
			2915 Hickory Leaf					Spring			Montgo		
ı	Funeral Director		418-40-9943	7. Age (	75 Y		Inder 1 Year onths Days	If Under 24 Hr Hours Mir		th ay, Year) 3, 19	9. Birth Cou 32 A1.	place (State or Foreign Intry) abama	
	and		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town	or Location	1					10d. Inside City Limits	
	Manyi 1 sho	ō	Maryland Montgome			ver S						1 Tes 2 No	
	the 28a-	rect	10e. Street and Number	- 7	011		f. Zip Code			10a. Citi	zen of What Cou	intry?	
	3a or	by Funeral Director	2915 Hickory Leaf	Way			209	20%			USA	,	
	deati			2. Was Decedent Eve	er in U.S.	13. Was [			Specify Yes or No into Rican, etc.)	o-	14. Race - Amer		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-1 show aumatic event, the Medical Extrainer must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces?  1 Yes 2 No If Yes, Give VI Year or Dates:—E.	ETNAM-		es 2□xvo	Specify:	into Mican, etc.)		Black, White Specify: W	nite	
2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. l	Decedent's	Usual Occupa	ition	odkina	16b. Ki	nd of Business/Ir	ndustry	
2	ithin 196	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		_		furing most of w	Urking	1	lding		
2	led w lygier her th	S	12			Stone	nason			1	structio	on	
and	8 E 5 S	Be	17. Father's Name (First, Middle, Last)	-1					ame (First, Middle		Sumame)		
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	Physician		Immediate Cause (Final disease or condition CARDTOPHT MONARY ARREST										
	/Medical Examiner		resulting in death)	Due to (or as a c									
		ē	Sequentially list conditions, if any, leading to immediate  b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE  Due to (or as a consequence of):										
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a c	bud to (or as a consequence or).								
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O. Box	at the death certif by the attending tached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of deli    1								ery Day Year	
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ecords,	w requires that s been signed t should be det	e Completed by								Yes 2		bably 4 🛣 Unknown	
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	ling After Iune		27. Manner of Death  12. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury World			28c. Injury Work		28d. Describe how injury occurred				
=	5 th 5 c	ertlflcation:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S					28f. Location ( City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Hospita 4 hours Funera ely fille	dical C	29a. Certifier  (Check only const.)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									stated, o the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	one) and manner stated.  29b. Signature and title of certifier 29d. Date signed (Mor										
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	2011	-	30. Name and address of person who con	Med to eause of death	(item 23a) /T	vna Print)	U.			J J I O I			
R	(3) Va		MARCUS P. NADLER,				STREET	אש שא	<b>СИТИСТОМ</b>	.DC 1	ንበፈንን /ፍ፬	8	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature		PIKUL	ATT O TITLE	THURION	, 1/4	-V444/00	<b>V</b>	
	Registra		OCT 2 9 2007	en D.	bound								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Wilnete B. Johnson 28 2007 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2**ĕ**F Min. Director 578-54-6518 81 9/9/1926 Richmond, VA Usual Residence of Decedent 10a. State MD 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 TYes 2 No Director Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1710 Mystic Ave 20745 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify 9 3 ☐ Widowed 4 A Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Daycare Provider Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Bernard Johnson Emma Lockett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Smith / Granddaughter 1604 Catherine Fran Dr., Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Fort Lincoln Cemetery 11/3/2007 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home β401 Bladensburg Rd., Brentwood, MD 20722 23a. Part 1 Enter the diseas shock, or heart failure. ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): SEPSIS Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that is its total and the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the c Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page 2 No certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Director: / hours after within 24 hours af

To the Funeral D

completely filled in

3altimore, Maryland 21215-0036

Medical State Registrar

Muchandows.

MD 0048123

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC AUTWI- DONKOR 9131 PISCATAWAY ROAS SUITE 750 20735 CLINTON

31. Date filed (Month. Dav. Year) NOV 0 1 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signa

			For	State of I	Marylan		artment of H		Mental Hy	gien	е			
			1 - State Registrar			Cei	rtificate of L	Death		Reg. N	.2007	36470		
г	Physici	an	Decedent's Name (First, Middle, Las	,					2. Date of De Month		2007 Year	3. Time of Death		
	/Medic	al .	Patricia Marie J		,		41. O't. T.	The second second				3:30 P M		
	Examin	er	4a. Facility Name (If not institution, give		er)		4b. City, Town, or		n	4	c. County of Dea	_		
	<u> </u>		Laurel Regional  5. Social Security Number 6. S		Age (In vrs	last birthday)	Lau1	If Under 24 Hrs.	8. Date of Bir	rth_		George's		
h	Funeral Director		-	□M 2⊠F	52	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Yea	r) Co	thplace (State or Foreign buntry) hington, DC		
6			Usual Residence of Decedent		32				July 3	1,	1933 Was	nington, be		
	yland now		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits		
	a-f st	ior	Maryland Prince G	eorge's		Laure	1					1 ☐ Yes 21 No		
	or 28	Director	10e. Street and Number			_	10f. Zip Code			10g. C	citizen of What Co	ountry?		
	th wi	al	11656 South Laur	el Drive	, Apt	2D	207	708			USA			
	r dea	Funeral	11. Marital Status	12. Was Decede Armed Force		S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puerl	pecify Yes or No to Rican, etc.)	)-	14. Race - Ame Black, Whit			
36	s afte or it		1 □ Never Married 2 □ Married	1 ☐ Yes 2 If Yes, Give		1 -	1 ☐ Yes 2 🛣 No		,		Specify: Wh	· ·		
21215-0036	e flied within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Date	s:	16a Dooo	ient's Usual Occup	otion		4.Ch				
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12	withi ene. than he M	Ę.	Elementary/Secondary (0-12)	College (1-4d	or 5+)		ntal Assi				ivate ntal Pra	ation		
	filed Hygi other ent, t		17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle			ictice		
Maryland	ld be ental ked c	To Be	Robert Lee Baldw	in				Maria H	Biancani	11م				
3	shou nd M mar	-	19a. Informant's Name/Relationship (7			19b. Mailir	g Address (Street a					Zip Code)		
	nd 2 alth a 27 is r trau		Robert M. Page -	Son		1717	Leisure V	lay, Crof	fton, MD	2	1114			
ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other plac	م ا	Date	20c. l	Location - City or	Town, State		
altimore,	Page ent o nt: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ie		n <b>Cremator</b>	1	27/07	A.1	exandria	a, Virginia		
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m	an me		- Muchely C Als	ente 1	10149	Ga Ga	sch's Fur	neral Hor	ne, P.A.	Ну	attsvill	e, MD 20781		
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	Physician		// shock, or heart failure. List only one cause on each line.  Immediate Cause (Fin  Carcinoma Lung											
	/Medical		resulting in death)	a Due to (or	as a consequ	uence of):						-		
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	cate be executed physician and the burial-transit	dical		.d								<u> </u>		
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å	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 ☐ Feta	Idéath 3□	Ectopic pregnancy Other (specify)			227	23d. Date of de Month	Day Year		
o.	y the	ıysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknowr		ou o_								
т. Г	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	ద	Part II. Other significant conditions of	ontributing to death	but not resu	alting in the ur	nderlying cause give	en in Part I.	23e. Did t	tobacco	use contribute to	the cause of death?		
Vital Records, P.O. Box	quires n sign	Completed by	Hepatitis C					·	1점	Yes :	2 □ No 3 □ Pi	robably 4 Unknown		
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8	The Is te has age 2	m o							auto perfo	psy ormed?	death?	utopsy findings available completion of cause of		
ta		BeC	25. Was case referred to medical					26. Place of Dea	1 Yes	2 🔯 N	lo I L Yes	2 □ No		
>	ysici is cer direc	일	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 23 Inpa	atient 2	ER/Outpatien	t 3 DOA Othe	Ar.			6 ☐Other (Spe	ecify)		
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director;	Med	29b. Signature and title on certifier	and manner	stated.	000/	29c. License				ate signed (Mont			
1	¥ <u>1</u> ≥ 2 8	_		1/11	11/	1111	D19:							
۸	7	-	20 Name and address of a second		f death //:-	200) 7		220			10/25/07	<i>.</i>		
1	(5)		30. Name and address of person who delta. Neil A. Meade	ompleted cause o 9811 Ma1:				20708						
- 2	Sta	te	31. Date filed (Month, Day, Year) OCT 2 9 2007	32. Regi										
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07-08550 Karl E Jennings Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

l E Jennings		_		ate of Ma	aryland	/ Depart	tment of	Health and	d Menta	al Hygiei	ne Reg.	No	20	07	3647
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Physicia: Examin احماط	-		ARL EARLSTON		NGS						vember 3	, 2007		1130	nrs
Z Examin			acility Name (if not institution			)	4	b. City, Town, or	Location of	Death			y of Death George		
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Funeral	T	5. S	ocial Security Number	6. Sex	7. A	ge (In yrs. las		If Under 1 Year Months Days		A fire			roleig	n untry) N	1
Director		:	214 72 3146	1 X M 2	F		50 Yrs.				2/16/	1930			11
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11215-0036 Iden filed within 72 hours after death with the Maryland fetal Hygiene. Tarked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.			Marital Status	12. W	as Deceder	nt Ever in U.S	S. 13. Wa	as Decedent of Hi	spanic Origi	in? (Specify	Yes or No-		ace - Amer /hite, etc.	ican India	n, Black,
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her de				orced If Yes,	Give Year			Yes 2 X No			dana T	Speci 16b. Kind o		ACK	
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Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		24	Signature of Funeral Service	e Licensee	0 0	λ	22 M	Name and Addre	S FUN	ĚRAL H	OME O	F MARY	VD 20	,INC.	•
<b>W</b> 5 9 <b>E</b>			Part I. Enter the disease,	1 000	as that caus	ed the death	Do not enter	308 SUIT	g, such as	cardiac or re	spiratory arre	est, shock, o	or heart	Appro	oximate Interval veen Onset and
Physician 'edical		23	hailure. List only one caus	e on each in	Ե.									Detw	Death
aminer		Im	nmediate Cause (Final diseas r condition resulting in death)	se a. H	yperten	nsequence o	heroscle of):	erotic card	novasc	mar oi	sease				
			equentially list conditions,	b.											
	ner	if	any, leading to immediate ause. Enter Underlying Caus		o (or as a co	onsequence	of):								
	Examiner	([	Disease or injury that initiated vents resulting in death) Las	· · · · · ·	o (or as a co	onsequence	of):								
be executed sician and urial - transit	Ě		Vertica reconstruig in Tables,	d								-		+-	
e exec cian al	dical		XUNPENDED	☐ <b>4</b> #	ZSa,PII	.27 <u>, per</u>	ME.g874.	12/11/07	ТТ			23d D	ate of deliv	very	
tox 68760, leath certificate be attending physic for use as the bu	Me.	IF 23	FEMALE: 3b. Was decedent pregnant in		Sc. If yes, ou	tcome of pre		Fetal death	3 Ector	oic pregnanc	у		onth	Day	Year
68° certifi nding	sician/Me	3   2	past 12 months?	4		nt at time of c		Other (Specify)				ļ			
Box 68760 e death certificate be the attending physical perfort use as the buck to the buck to the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buck the buc	j		100 2	Jnknown g	Unknow			. 1	a siyon in l	Port I	23e. Did 1	tohacco use	contribute	to the ca	use of death?
b.O. I that the ned by the	10	F	Part II. Other significant con	ditions con	tributing to	death but not	t resulting in tr	ne underlying caus	se giveiriiri	arti.		s 2 🗸 N			
i, P.O.	1	2	Cocaine use								24a. Was	an	24b. Were	autopsy	findings available
rds v requ	1 2											ormed?	death	h?	etion of cause of
eco he lav ate has	Completed											2No	1 🗸	Yes	2 No
Ann: T entifice	d'in	ט ו ע	25. Was case referred to med		itali 🖂				Other	th (Check or	Home 5	Residenc	e 6 🗸 0	ther: Scer	ne
Vita hysicia this co			examiner? 1 ✓ Yes 2 No	Hosp		patient 2	ER/Outpat 28b. Time		Injury at W		28d. Describe				
of ing Pl	unera		27. Manner of Death  1 X Natural 5		28a. Date of (Month,	Day,Year)	200. Time		Yes 2						
sion trtend death.	y me	Ĭä.		Pending nvestigation	28e Place	of Injury - A	t home, farm,	street, factory, off	ice building	, etc.	28f. Location	(Street and	Number o	r Rural Ro	oute Number, City
Division of Vital Records, tal or Attending Physician: The law require rs after death.  The third physician is a property of the physician has been single to the construction name of should be a feet that the construction name of should be a seen single or the construction name.	a ui p	Certification	3 dicide	Could not be letermined	(Specify)						or Town,	State)			
<u>.</u> 2 2 2			4 Homicide 29a. Certifier 1 Certifyin	o Physician:	To the best	t of my knowl	ledge, death o	ccurred at the tim	e, date and	place, and	due to the ca	use(s) and	manner as	stated.	100(0)
the H lin 24 the F	completely		(Check only one) 2 Medical	Examiner:Or	the basis o	of examination	n and/or inves	atigation, in my op	IIIIOII, deati		the time, da				Day Voarl
5. i i ot	100	ĕ⊦	29b. Signature and title of ce		0.			1	cense numb	рег			ete signed ember 4,		ouy, rour/
			Mollone	Mrs. C.	Shill				).C.M.E.						
0		+	30. Name and address of pe		pleted caus	e of death (I	tem 23a)	1 Penn Stree	t. Baltim	ore, MD 2	21201				
W			Margarita Korell M			dical Exan	1	)	-,						
Reg	Sta	ite ar	31. Date filed (Month, Day NOV 0 8 2	J07 A	re-am	D.	Money								
	_	_													

DHMH 17 Rev 1/2001 OCME 2006

within 24 ho

To the Fun

completely 1 State Registrar

31. Date filed (Month, Day, Year) NOV 0 1 2007

29b. Signature a

10 32. Registrar's Signat

and manner stated.

Nam and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number MO 162

MO16

			_ For	State of Maryland	d / Depa	artment of I	lealth and			gibie.	
	Physici	an	1 - State Registrar 1. Decedent's Name (First, Middle, Last	,	Cei	rtificate of	Death	2. Date of De Month	Day	0,07	3. Time of Death
	/Medic		Purnachandra Ra					October	26, 2	2007	4:30 A M
i.	Examir	er	4a. Facility Name (If not institution, give 18915 Crosstie T				r Location of Dea	th		nty of Death	
مدد	Funeral	4.	5. Social Security Number 6. Se		ast birthday)	If Under 1 Year	nantown   If Under 24 Hrs	8. Date of Bir	th	Ontgome	ce (State or Foreign
	Director		220-59-9672 15 Usual Residence of Decedent	X ^{M 2□ F} 31	Yrs.	Months Days	Hours Min	(Month, Da August	^y 1 ^{Year)} 197	6 Indi	a
	Maryland f show ied at	tor	10a. State         10b. County           MD         Montgom		Germa	cation antown				100	I. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the la or 28a t be notif	<b>Funeral Director</b>	10e. Street and Number 18915 Crosstie Te	-		10f. Zip Code 2087	4			of What Country  Idia	1?
	death ms 23	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of I		Specify Yes or No	- 14. F	Race - American	
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1  ☐ Yes 2  ☐ No If Yes, Give Year or Dates:		If Yes, specify Cub I □ Yes 2[X] No	an, Mexican, Pue Specify:	rto Rican, etc.)	Spe	Black, White, etc cify: Asi	an Ind <b>i</b> an
215-0	hin 72 ho s. In "natur Medical i	Completed	15. Decedent's Edu (Specify only highest grad	cation de completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo d)	orking	16b. Kind of	Business/Indu	stry
212	d with giene er tha	E O		4	Comp	outer Pro	grammer		Comp	uters	
land	uld be file Aental Hy rked othe	To Be (	17. Father's Name ( <i>First, Middle, Last</i> ) Raghunadha Rao K	agita			18. Mother's Na Lakshmi	me (First, Middle, Vaka	Maiden Surr	name)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7) Siva Jampana / Wi			ng Address (Street Crossti					
nore,	ages 1 aent of He		20a. Method of Disposition 1 XBurial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify)	CE CE	emetery, crei	sition (Name of matory or other pla of Faith nistries	& Nov	ember 4		n - City or Town	sh, India
Baltir	permit. F Departme Importar any injur	0 10	21. Signature of Funeral Service Licens		22 I	Name and Addre DeVol Fur Gaithersb	ess of Facility Leral Hom	ne, 10 Ea			
		0. N	23a. Part1. Enter the of sease, or complete shock, or heart failure. List only of Immediate Cause (Final	ications that caused the death ne cause on each line.					rrest,	lr Ir	pproximate nterval Between onset and Death
P	Physician /Medical Examiner		disease or condition resulting in death)	a. Clear Cell  Due to (or as a consequ		ma				1	-year
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequ	ence of):						
2,092	te be executed lysician and ne burial-transit	ical Examiner	Cause (uisease or injury that initiated events resulting in death) Last	c	ence of):						
O. Box 68	The law requires that the death certificate to has been signed by the attending phy lage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3[	Ectopic pregnanc Other <i>(specify)</i>	у	-		Date of delivery Month D	ay Year
rds, P.	quires that the de n signed by the a ald be detached f	by	Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did to			cause of death?
Vital Records,	Physiclan: The law requir this certificate has been si al director, page 2 should	Completed						24a. Was autor perfo 1∐ Yes		prior to comp death?	y findings available letion of cause of
VII:	iclan Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		104		ath (Check only o			
or	Phys this a	D .	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien 28b. Time of		4 🗀 Nursing i	Home 5 Resid			
u C	ding Ph J. After th funeral	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	ryat k? Yes 2∐No	28d. Describe h	now injury occ	eurred	
Division or	Atten r death ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hol building, etc. (Specify	me, farm, str		res 2 INO	28f. Location (S City or Tox		mber or Rural F	Route Number,
	Hospital 4 hours a Funeral tely filled	Medical Ce	29a. Certifier (Check anily one)  12 Certifying Phy 2 Medical Exami	sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or in	occurred at the tivestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and date and plac	manner as stat e, and due to the	ed. ne cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of pertifier	and marrier stated.		29c. Licens	e number		29d. Date sig	ned (Month, Da	v. Year)
2	C		1 thely >			D	52767			29-2007	
	(e	}		ompleted cause of death (Item	23a) (Type:						
			Harminder Singh Se			est Glen	Rd #435	: Silver	Sprin	a, MD	20910
	Sta	_	31. Date filed (Month, Day, Year)  OCT 3 0 200	32 Registrar's Signat			.,, - 30				
	Registr	ar	001 30 200	BORNES D	A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR	HEL.					

Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health Certificate of Death	and Me	ental Hygi	ene 2 n n	7 361.75	1
		-	Registrar  1. Decedent's Name (First, Middle, Last)		Reg		3. Time of Death	_
,	Physici		John J. Lighter JR.			24,2007	9:44 am ^M	
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location			4c. County of [		_
	Mag.		Prince Georges General Hospital Cheverly			Prince	Georges	
Ž.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If U		B. Date of Birth (Month, Day, )	9	Birthplace (State or Foreign Country)	
k	Director		213-22-3082 X Yrs.		eb. 22,		laryland	_
	land w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	-
	Mary -f sho	ģ	MD Prince Georges Bowie				1 □Yes 2√□No	
	r 28a	irec	10e. Street and Number 10f. Zip Code		109	g. Citizen of Wha	t Country?	_
	th with	a D	12324 Manship Lane 20715			USA		
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Ol If Yes, specify Cuban, Mexica	Origin? (Speci	fy Yes or No-	14. Race - /	American Indian, White, etc.	
98	after or it	y.F.	1 □ Never Married 2 Married   1 M Yes 2 □ No Vietnam 1 □ Yes 2 No Specify		, 5.5.,	Specify:	White	
ğ	hours tural"	d by	3 Vidowed 4 Divorced Year or Dates:					
쟌	n 72 ' "nai ledica	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during modifie. DO NOT use retired)	ost of working	, "	6b. Kind of Busin	ess/Industry	
75	withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Officer			U.S	.A.F.	
ğ	e filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)  18. Moth	ther's Name (i	First, Middle, Ma	aiden Surname)		-
<u>la</u>	uld be Aenta rked tic ev	To B	John J. Lighter SR. Mar	rie		Shank		
Maryland 21215-0036	and has ma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Numb				te, Zip Code)	_
	and 2 ealth n 27		Clara J. Lighter Spouse 12324 Manship Lane			715		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory	Dat 10/27	.   -	oc.Location - City altimore		
Balti	permit. Departm Importa any Inju		21. Signature of Foneral Service Licensee  22. Name and Address of Facil Hardesty Funer	ral Hor	me P.A.	12 Ridg	ely Aye,Apn,M	– D
ě.			23a. Part1. Enter the dis the end or complications that caused the death. Do not enter the mode of dying, such as shock, or heart fail the List only one cause on each line.				Approximate	_
	Physician		Immediate Cause (Final	Hear	2	,	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	,				_
3	Examiner							
		ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Cause Finer Unique Transfer of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of t					_
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9	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):					
8760,	cate b	dical	d					_
9 ×	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy					
Box	death certifi e attending I d for use as	Physician/Me	in the past 12 months?			23d. Date of Month	f delivery Day Year	3
o.	0 0	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown					
<u>.                                    </u>	The law requires that the de te has been signed by the rage 2 should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I.	23e. Did toba	cco use contribu	te to the cause of death?	1
ğ	quire n sig uld b				1 ☐ Yes	2 No 3	Probably 4 Unknown	1
Records,	aw re s bee	Completed			24a. Was an	24b. Wer	e autopsy findings available	
	The lav	E O		-	autopsy performe 1 Yes 2-	prior	r to completion of cause of the	
Vita	sician: Th certificate rector, pag	BeC	25. Was case referred to medical 26. Place	ice of Death (0	Check only one)		TES ZUNU	-
	hysician: this certific al director,	To E	examinar?  1  les 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 No	Nursing Home	e 5 ☐ Residen	ce 6 □Other (	Specify)	
0	ding Pt After th funeral		27. Manner of Death 28a. Date of Injury 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☐ Natural 28b. Time of Injury Work?	280	d. Describe how	injury occurred	500-	
<u>S</u>	Attendideath.	cati	2 Accident investigation Octobe 24,257 9.44M 1 Yes 2					
Division or	al or At s after d il Direc	Certification:	3 ⊈ Suicide 4 ☐ Homicide determined 28e. Place of injun - At home, farm, street, factory, office building, etc. (Specify)	281		et and Number of State) 123	Rural Route Number	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	and place, and leath occurred	d due to the cau	use(s) and manne e and place, and	er as stated	
	To the To the Comp	Me	29b. Signature and title of certifier 29c. License number	6-	290	I. Date signed (M	donth, Day, Year)	
			Harabu /grater 70 HOOSS	11	/ C	color	21, 2007	
	13. W		29b. Signature and title of certifier  29c. License number  1 + 0053  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  5 + 0053  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  5 + 0053  30. Date filled (Month, Day, Year)  32 Registrar's Signature	ine	Clar	orly, 1	ungland	
	Sta Registr		31. Date filed (Month, Day, Yelfr)  OCT 2 9 2007  Some If Sports	/			•	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Netober 4c. County of Death 4b. City. Town, or Location of Death Lanham

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Physician Joan K. Lynch /Medical 4a. Facility Name (If not institution, give street and number) Examiner Doctor's Hospital 5. Social Security Number **Funeral** 1 □ M 2 🕅 F 139-24-7117 Director Usual Residence of Decedent 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director MD Prince George's 10e. Street and Number 6273 67th Court Funeral 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 2 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 ulth and Mental Hv 17. Father's Name (First, Middle, Last) Be ဥ Walter Kirk 19a. Informant's Name/Relationship (Type. Print) Kelly J. Lynch / daughter 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Pervice Dicense Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Examiner

Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 76 Newark, NJ 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Riverdale 10f. Zip Code 10g. Citizen of What Country? 20737 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes X No Specify: Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) Mary Savage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1464 Orleans Court Crofton, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 10/30/2007 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home

6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARBIOMMODATH L SEVENE

ENCED HALDPATITY

SEVERE Due to (or as a consequence of)

STAT ILS EPILEPII CUS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

5 ☐ Other (specify)

3 Ectopic pregnancy

23e. Did tobacco use contribute to the cause of death?

1 Tes 2 No 3 Probably 4 1 Inknown

23d. Date of delivery

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2000

di sease

24a. Was an autopsy perform 2 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No

Day

Approximate Interval Between Onset and Death

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

29a. Certifier (Check only 29b. Signature and title of certified

In certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 26280 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

od Luck Rd. Lanham mo NOV 0 1 2007

State Registrar

requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division or Vital

Hospital or Attending

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Physician/Medical

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Completed

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Certification:

Medical

physician

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Brenda Eleanor Lockard Oct 28, 8:45 P /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3904 Stoconga Dr. Prince George's Beltsville 8. Date of Birth (Month, Day, Year) Aug 15, 1958 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 🕅 F Pennsylvania 49 Director 212-64-6102 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or its any Injury or other trainment. 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zin Code 10a. Citizen of What Country? 1368 South Carolina Ave. SE 20003 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John David Lockard Mary Rowland ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Martin Lockard - Brother 3904 Stoconga Dr., Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place)
Centre County
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State State College, PA 4 Donation 5 Dother (Specify) 12-10-07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. 373 Gasch's Funeral Home, P.A. Hyattsville, MD 20781 AMULL 2 9 Part1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ovarian Cancer /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2XNo the 9 I Inknown 9 ☐ Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 ☐ Yes 2 XNo ျှ 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

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completely filled in 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29142 10/30/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Charles Boyce, MD 10301 Georgia AVe, Ste 205, Silver Spring, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2007 Registrar

DHMH 17 Rev 1/200

Division or Vital Records, P.O. Box 68760

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	sician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each	Stions that caused the death, Dine.	o not enter the m	node of dying,	such as ca	diac or respiratory ar	rest, shock, or heart		ximate Interval een Onset and		
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	physic he bu			23c. If yes, outcome of pregna	incy			7 2 7 1 1 1 1 1	23d. Date of de	livery			
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Division of Vital To the Hospital or Attending Physician:	within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician	To the best of my knowledge n the basis of examination and	, death occurred						(s)		
A	To Com	ig ig	29b. Signature and title of certifier	nd manner stated.		29c. Licens			29d. Date signed				
4	1		200. Signature and file of certifier	1150		O.C.I			October 28, 2		, i cai /		
1.	5		Muna Grasse	4.1118		0.0.1	IVI. Ľ.		October 26, 2				
	10		30. Name and address of person who con		,	- 01	-16	MD 64.004					
_ /	10 11		Melissa Brassell, MD Assi	stant Medical Examine	r 111 Pen	n Street, B	aitimore.	MD 21201					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:55/M 1-1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 79 Months Days Hours Min Director 256 25 5528 SEPT 27,1928 KOREA Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD HOWARD ELLICOTT CITY 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3536 LOWLEN CT Funeral 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡No Specify: Specify: ASIAN 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 MAINTENENCE MECHANIC PRIVATE 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be HYO JUNG GI NEM CHO ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER HAN/ DAUGHTER 3536 LOWLEN CT ELLICOTT CITY MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □R 4 □Donation 5 □ Other (Specify) 3 ☐Removal from State CREST LAWN MEM. GDNS.10/26/07 MARRIOTTSVILLE MD 21. Signature of Fundal C 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 12303 KAYAK DR UPPER MARLBORO MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOUL **Physician** /Medical Due to (or as a consequence of): Examiner DISEACE Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and 10mg certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ē in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No.... 24a. Was an autopsy performed? certificate Division or Vital 2 -No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 LNC 1 Depatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? I Director: After to d in by the funera 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Vithin 24 hours after To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR (2)

State Registrar 31. Date filed (Month, Day, Year)
OCT 2 9 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 36480 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** THERESA Ann LAWRENCE October 2007 11:55 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE 13417 GRENOBLE DRIVE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. 16 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 034-18-7990 81 Yrs. Director 1926 Massachusetts Usual Residence of Decedent with the Maryland in than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Director Montgomery Rockville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13417 Grenoble Drive 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Item any injury or other traumatic avent, the Medical Enumera Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Joseph Lynch, Sr. Mary Catherine Healy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur J. Lawrence, Sr./Husband 13417 Grenoble Drive, Rockville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 10/30/07 Gate of Heaven Cem. Silver Spring, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home H. P. O. Box 5038, Laytonsville, 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Vhet Onset and Death asyases **Physician** mon /Medical Due to (or as a consequence of) Examiner Breas Cancer FORS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by I be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21910 my October 24. 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3921 Ferrara Drive, Silver Spring, Md. 20906 Peter B. Sherer, M.D. 31. Date filed (Month) 32. Registrar's Signature State 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 07:00 ам Baoming Liu October 27 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F Director 68 216-21-3586 December 03,1938 China Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be accounted. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Autumn Wind Way 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: <u>Ş</u> 3 Widowed 4 Divorced Asian Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer IT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yuanging Liu 2 Yunxiu Huang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Xiaochuan Ge - Spouse 115 Autumn Wind Way, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 11/03/2007 Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sersis Unknown /Medical Due to (or as a consequence of): **Examiner** Hodgkin Lymphoma Unknown Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was c. autopsy performed? Yes 2 No page certificate 1∐ Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062 99 9 October 27, 2007

Registrar
DHMH 17 Rev 1/2001

State

Petek Donmez, M.D., 11119 Rockville Pike, #401, Rockville, Maryland 20852

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 0 2007

31. Date filed (Month, Day, Year)

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Bruce 25, LeMessurier 2007 /Medical October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 15101 Glade Drive, # 1C Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 131-16-5701 81 May 11, 1926 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 15101 Glade Drive, 20906 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1943 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 1 ☐ Yes 21 No Specify 3 ₩ Widowed 4 Divorced 1946 Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u> Intelligence Research Specialist</u> traumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If iten 27 is marked ofth any fujury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde LeMessurier Esther Bentley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Maryman/Daughter 4811 Strathmore Avenue, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 27 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2007 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses  $\downarrow 10$  East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke 1 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Undeath of that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Diabetes, Hypertension, Hyperlipidemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

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Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State

Registrar

Christopher C. Dunford, M.D., 615 West Montgomery Avenue, Rockville, MD. 20850 31. Date filed (Month, Day, Year) 32 OCT 30 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. **B**egistrar's Signature

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October 26, 2007

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al Examin	ier	JEREMY ALLEN LOVE		October 27,		0354 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town  MD Rte 313 near Three Bridges Road  Federals	n, or Location of Deatl	n	Caroline	m
	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		s. 8. Date of Birth(	MM/DD/YYYY) 9. Bi	irthplace (State or
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5-0036 led within 72 hours after tygiene. other than "natural", the Medical Ex miner.	화	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Oc	cupation (Give kind of	work done	6b. Kind of Business	s/Industry
72 hor	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		tired)	Ol	,
1036 vithin 72 ene. er than	m L	12 Machine Op			Chemica	T
filed v filed v Hygi d oth		17. Father's Name (First, Middle, Last) Augustus Love	Linda	ne (First, Middle, Ma Tull	aigen Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	o Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (	Street and Number or	Rural Route Numb	er, City or Town, Sta	ite, Zip Code)
MD 21215-0036 d 2 should be filled within 72 hours after death with the Maryland lith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she animatic event, the Medical Ex miner must be notified at once		Mary Ellen Tull - grandmother 305 Hickor	y Lane, Se	eaford, D	E 19973	
e, land I and Health	ı	20a. Method of Disposition (Name crematory or other place)			20c. Location - City	or Town, State
Baltimore, MD 21215-003 pernt. Pages I and 2 should be filted within Department of Health and Mental Hygiene. Important: If iten 27 is marked other thinjury or other transmatic event, the Med		1 X Burial 2 Cremation 3 Removal from State Odd Fellows Cerr 4 Ponation 5 Other Specify:	etery   13	L/01/07	Seaford	, DE
altin mit. partm porta	ļ	21. Signature of Funeral Sendre Licensee. 22. Name and Ad	dress of Facility on Funeral	Home		
		John A. Cranston P.O. Box 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of c	. 967. Seat	ford. DE	19973	Approximate Interval
hysician /Medical		failure. List only one cause on each line.	lying, such as cardiac	or respiratory arres	st, shook, or hourt	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Multiple Injuries  Due to (or as a consequence of):				
		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit		d				
be exe	Medical	UNPENDED AMENDED				
760, ficate b	//Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic preg	nancv	23d. Date of deliv Month	ery Day Year
Box 687 e death certificathe attending ped for use as the	ciar	past 12 months?  4 Pregnant at time of death 5 Other (Specification of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro				
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P.O. es that the		Part II. Other significant conditions contributing to death but not resulting in the underlying c	ause given in Part I.			Probably 4 Unknown
S, P.(	Completed by			- 24a. Was a		autopsy findings available
cords, law requir has been s	ple			autops perform	y prior t	to completion of cause of
Rec The l icate l	Con		D 12 (0)	1 ✔ Yes 2	No 1 🗸	Yes 2 No
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	Place of Death (Che		Residence 6 🗸 Ot	ther: Scene
Division of Vital Records, real or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be a possible or the funeral director.	. To	1 ✓ Yes 2 No Impatient 2 Elevation 22.  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b.	c. Injury at Work?	28d. Describe h	ow injury occurred	
on C nding nth.	tion	1 Natural 5 Pending Oct 27, 2007 0343 hrs	1 Yes 2 V No	Driver auto a	uto collision	
ivision  or Attendi after death. Director:	fica	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, or	office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Div	Certification:	4 Homicide determined (Specify) Major Road / Highway		MD Rte 313 ne	ear Three Bridges	Road, Federalsburg, M
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the to the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired management of the desired m	ime, date and place, a	and due to the cause	e(s) and manner as s	stated.
To the I within 2 To the Complet	Medical	and manner stated.	License number	o di trio timo, dato t	29d. Date signed (	
10	2	255. Signature disa title of sortino	O.C.M.E.		October 27, 20	
10 RU		your statel 1110				
0		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Stro	et, Baltimore, M	ID 21201		
St	tate	31. Date filed (Montes), Yar/1 2007 32. Fustrar's Signature				
Regis		001 0 - 2001 Julian			CIVIE	

ORIGINAL

			1 - For State Registra MEND#29 cperiMD	State of M ,11/6/07,BM	aryiani MoCo		rtificate of	neaith and i Death	, ,	IENE eg. No.	
**	Physici /Medic		1. Decedent's Name (First, Middle, Las	st)		, JR			2. Date of Deat Month OCT . 1	Day Year	3. Time of Death
-	Examir		4a. Facility Name (If not institution, give	street and number)		•	**	r Location of Death		4c. County of Death	
-	Funeral Director		Montgomery Ger 5. Social Security Number 6. So 212-98-5314	ех 7. Ag	100 74	al ast birthday) Yrs.	If Under 1 Year Months Days	Iney   If Under 24 Hrs.   Hours   Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign
	70	ctor	Usual Residence of Decedent 10a. State 10b. County	Jomery		, Town or Lo	rwood		sept, 2		7irginia 10d. Inside City Limits 1⊠Yes 2□No
	th with the 23a or 28 ist be not	<b>Funeral Director</b>	10e. Street and Number 16217 Gristn	mill Dri	ve		10f. Zip Code	0855	1	0g. Citizen of What Cou	
5-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funer	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2€ No	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
0-61212	filed within 72 ho Hygiene. Ather than "natur ont, the Medical.	Be Completed by	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12) 1.2 th	ucation de completed) College (1-4or 5	5+)	(Give life. L	lent's Usual Occup kind of work done o OO NOT use retired Disable	during most of work d)	ing	16b. Kind of Business/In	dustry
yland ;	0 9 9 0	To Be C	17. Father's Name (First, Middle, Last)  Robert Mille	er				18. Mother's Name			
Mar	and 2 shoul ealth and Me n 27 is marl		19a. Informant's Name/Relationship (7 Barbara Miller		c)					City or Town, State, Zip	
Baitimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donei on 5 □ Other (Specify		1	lingt	sition (Name of natory or other place on Nat'	1 Cem 1	1/26/07	Pt. Mye	r, VA
Pall	permit. Depart Import any inj		21. Signature of Funeral Service Licen	Luce	ech	22	. Name and Addres	ss of Facility ${ t SNC}$	OWDEN F	UNERAL HO	ME, P.A.
	Physician /Medical Examiner		23a. Fart1. Enter the diser se, or com- shock, or heart failur. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	Navi	q	er the mode of dyin	ig, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
00/00	rificate be executed g physician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Uncertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  c  Due to (or as			_				
DOX .	death certi e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
ecords, r	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co	entributing to death be	ut not resul	ting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to the	
ייים ויי	: The law re cate has bee	Completed							24a. Was ar autops perform 1 Yes	prior to condeath?	opsy findings available impletion of cause of
V   [a	Physiclan: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2□E	R/Outpatient	3 DOA Othe	26. Place of Death			
5	nding Phy ath. r; After this e funeral d	H 1	27. Manner of Death   SNatural 5   Pending 2   Accident investigation	28a. Date of Injur (Month, Day	ry	28b. Time of Injury	28c. Injury Work	/ at	me 5 ☐ Reside 28d. Describe ho	nce 6 ☐Other (Specifi w injury occurred	<u>y)</u>
2	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubility building, etc.	c. (Specify)				City or Town		
	the Hospi hin 24 hou the Funer npletely fill	Medical	one) 2   Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinati	rledge, death on and/or inv	estigation, in my o	pinion, death occurr	red at the time, da	use(s) and manner as sate and place, and due to	o the cause(s)
		_	29b. Signature and title of certifier	MP	_		Descri	9 number D0063	3196 29	d. Date signed Month,	Day, Year)
			30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person and address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person a	ompleted cause of de	01 A	11110	Pulip	prive	divay	MD 208	(32
	Sta Registra		OCT 3 0 200	7 Harristo	o orginali	dos	all B		1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ber Linda J. McDonald 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Anne Baltimore Washington Medical Center 3m If Under 1 Year 5. Social Security Number Under 24 Hrs. 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1/2/1949 **Funeral** 9. Birthplace (State or Foreign 1 □ M Months Days Hours Min. Director 073-40-9737 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits items 23a or 28a-f shoviner must be notified at MD Anne Arundel Odenton Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Topaz Ct. 21113 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14 Bace - American Indian Examiner filed within 72 hours after Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: ō White 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: If Item 27 is marked other than College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Macco Jean Simone ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin McDonald Husband 1205 Topaz Ct. Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10/24/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Pdr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) C-a)) Physician usm ow /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-t Due to (or as a consequence of): ng physician a requires that the death certificate be Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy certificate perform 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No Director: 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

130

OCT 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30 egistrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box

P.0

Records,

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Division

29c. License number

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

Director

Funeral

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Completed

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

alth and Mental Hygiene.
27 is marked other than 's traumatic event, the Me

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra

Baltimore, Maryland 21215-0036

burial-tran attending physician for use as the buris been signed by the should be detached certificate has be rector, page 2 s

Physician/Medical

Completed by

Be

Certification; To

Medical

The law requires that the death certificate be executed or Attending Physician: funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

Hospital

the

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☐ Homicide

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) tated

29b. Signature and title of partific

29c. License number

29d. Date signed (Month, Day, Year) EXENSE HIGHWAY ANNAPOLYMDZIYO)

State Registrar

31. Date filed (Month, Day, Year) 0CT 2 6 2007

determined

ENTA

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		partment of F			giene Reg. No. 200	7 36488
	Physici /Medic		1. Decedent's Name (First, Middle, Las Eve Loretta	MacCracke	en				29, 2007 Yea	2:20 P M
	Examin Funeral Director	er	5/7-22-0362	ted Living Fac		Нуа	ttsville If Under 24 Hrs. Hours Min.	8. Date of Birl	th 9. E	nce George's Birthplace (State or Foreign Country) PA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleam 27 is marked other than "natural!" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent  10a. State  Maryland  10b. County  Prince  10e. Street and Number  3703 Windom Road	George's	y, Town or P	entwood 10f. Zip Code	722		10g. Citizen of What	•
0000	ours after death ral", or items 2; Examiner mus	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	.S. 13	I B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No o Rican, etc.)		merican Indian,
D-C   7	within 72 ho iene. than "natu ho Medical	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ducation de completed)  College (1-4or 5+)	16a. Dec (Giv liife.	pedent's Usual Occup ve kind of work done DO NOT use retired Domestic	eation during most of wor d)	king	16b. Kind of Busine:	ss/Industry
Iailu z	uld be filed Aental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Middle, Last, John Meshula					ne (First, Middle, Anna Sen	, Maiden Surname) .ko	
z, Iviary	and 2 shortealth and Nortealth and Nortealth and Nortealth and Nortealth		19a. Informant's Name/Relationship ( Robert W. MacCrac	ken, Jr Son	370	0 S. West	port Ave		er, City or Town, State  37, Sioux F  20c. Location - City	Talls, SD 57106
Dallillore	nit. Pages 1 artment of H ortant: If Ite Injury or ot		20a. Method of Disposition  1 2 Burial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Service 1) (Service 1	(y) For	t Line	position (Name of rematory or other place coln Cemet 22. Name and Addre	ery 11/		Brentwood	, Maryland
Ö	permi Depa Impo any Ir		23a Part1. Enter the disease, or com	Moi H 9 )  Blications that caused the deat					. Hyattsvi	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma T						Onset and Death 8 months
L	- લુસ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
00/00	ifficate be executed g physician and as the burial-transit	ical	(	⊾d						
O. DOX	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	3□Ectopic pregnanc 5□ Other <i>(specity)</i> _	/		23d. Date of Month	delivery Day Year
cords, r.	equires that ten signed by ould be detact	þ	Part II. Other significant conditions	ontributing to death but not res	sulting in the	underlying cause giv	en in Part I.			e to the cause of death?  Probably 4X\(\sum_\text{Unknown}\)
		Completed						24a. Was auto perfo 1  Yes	psy prior ormed? death	
or vital	Attending Physician: r death. ector: After this certifice by the funeral director, g	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1   Inpatient 2    28a. Date of Injury (Month, Day Year)	ER/Outpati		er: 4 🖾 Nursing F		one) idence 6 □Other (S how injury occurred	pecify)
	Atter r deat ector by the	Certification:	1  Natural 5  Pending 2  Accident 3  Suicide 4  Homicide	e 28e Place of injury - At he	ome, farm,	M 1 1	Yes 2 □ No	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
נ	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Ce		nysician: To the best of my knominer: On the basis of examination and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Bow	>	29c. Licens D16	se number 5410		29d. Date signed (Me 10/30/20	
1	2 (10)		30. Name and address of person who Gabriel B. Jaf			e, Print) er Pkwy, S	Ste 105,	Greenbe	1t, MD 20	770

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Plea	se Type or Prin				-	•	
T = For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I rtificate of		_	ene g. No. O O O T	0.00
1. Decedent's Name (First, Middl	e, Last)				2. Date of Death	2001	3. Time of Bearing
Mary Virginia	Merryman				October	27. 2007	5:55 P M
4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
16539 Trenton 1	Road		Upperco			Baltimon	re
5. Social Security Number		e (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
218-10-0230	1 ☐ M 2 💢 F	86 Yrs.	Months Days	Hours Min.	Dec. 22,	1920 Mary	vintry) 7 land
Usual Residence of Decedent							
Maryland Balt:	imore	10c. City, Town or Le	ocation				10d. Inside City Limits 1 ☐ Yes 2 No
10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
16539 Trenton	Road		21155		1	ited Stat	
11. Maritai Status	12. Was Decedent B	Ever in U.S. 13.		Hispanic Origin? (Sr		14. Race - Ame	
1 ☐ Never Married 2 ☑ Marri	Armed Forces?			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:		Specify: Wh	nite
15. Deceden	it's Education	16a. Dece	dent's Usual Occur	pation	///1	6b. Kind of Business	/Industry
	st grade completed)	life.	kind of work done DO NOT use retire	during most of work d)	king		,
Elementary/Secondary (0-12)	College (1-4or 5	hor	memaker		(	own home	
17. Father's Name (First, Middle,	Last)	I		18. Mother's Nam	ne (First, Middle, M	laiden Surname)	
John Wilhelm	•			Clara Z		,	
19a. Informant's Name/Relations	hin (Tima Print)	10h Maili	ing Address (Street			City or Town, State, J	7:- 0-4-1
_							
Thomas Leo Mei 20a. Method of Disposition	rryman-nusbar		39 Trento			Maryland 2	
1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Disponentery, cre		. ויאו	31	Oc. Location - City or	
4 Donation 5 Dother (S			utheran (	em.	2007	Ipperco, Ma	aryland
21. Signature of Funeral Service	License	M01072 9	2. Name and Addre 34 South	ess of Facility E Main Stre		ral Home stead, Md.	21074
23a. Part1. Enter the disease, or	complications that caused						Approximate
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of): a consequence of): a consequence of):	1 Hyns	פוס			S Monut
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	⊒Ectopic pregnanc ☑ Other (specify) _	y		23d. Date of de Month	livery Day Year
Part II. Other significant condition	ons contributing to death bu	ut not resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
					_		
					24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medica	<u> </u>			OR Disease D		QNo 1 □ Yes	2 No
examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie.	nt 2 ☐ ER/Outpatie	nt 30 DC4 Oth	OF:	th (Check only one		
27. Manyler of Death	28a. Date of Injur		III JUDON	4 LI Nursing Ho	ome 5 Resider 28d. Describe hov	nce 6 Other (Spe	city)
1-ENatural 5 ☐ Pendir	ng (Month, Day		Wo	rk?  Yes 2∐No	200. Describe nov	winjury occurred	
2 ☐ Accident investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigned investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation in	not be	. At hame form at		Tres ZUINO	201		
4 Homicide determ	nined 288. Place of Inju-	rry - At home, farm, st :. (Specify)	геец тастоту, опісе		City or Town,	eet and Number or Ri State)	ural Route Number,
29a. Certifier (Check only one)  Certifyir 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	, and due to the car rred at the time, da	use(s) and manner as	s stated. e to the cause(s)
29b. Signature and title of certifie			29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
Dan W	aunde	MO	328	133		10/24/0	7
30. Name and address of person	who completed cause of de	eath (Item 23a) (Type,	Print)			-	
JOHN SA	MOER 65	69 NCH	ANCES -	51 420	SADIN	ONE MO	21204
31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	2/5				-
OCT 3	0 2007	1/4	And .				
0010	V COOL	New No.	Course				
		OR	IGINAL				

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Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician JEANETTE** MORRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTORS HOSPITAL PRINCE GEORGE'S LANHAM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💢 F 63 Director 578-96-6237 FEB. 1944 TRINIDAD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at PRINCE GEORGE'S Director BOWIE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with n and Mental Hygiene.

Is marked other than "natural", or Items 23a or 305 JERSEY COURT 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: USA Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN BODIE ပ CATON HILDA19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other trae PAMELA MORRIS/DAUGHTER 305 JERSEY COURT BOWIE, MARYLAND 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 10-31-2007 | RIVERDALE, MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician sircula disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sepson Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Neutropen in as the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has HIV Diseans 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral dire Certification: To 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how injury occurred Natural Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Medical

29a. Certifier (Check only one)

Box 68760,

P.O.

Division or Vital Records,

31. Date filed (Month, Day, OCT 3 1 2007

29b. Signature and title of certifier

helical

32. Registrar's Signature

Lovel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Lyck

and manner stated.

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00052865

29d. Date signed (Month, Day, Year)

October 29

(MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Meeks /Medical 24, 2007 <u>October</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Prince George's Clinton If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Social Security Number 8. Date of Birth (Month, Day, Year) Days 1 ☑ M 2 ☐ F Months Hours Director 598-88-0454 45 April 19, 1962 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a a or 28a-f shi Director 1 Yes 2 No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a or ir aumatic event, the Medical Examiner must be n 2412 Porter Avenue by Funeral 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Home Improvement Specialist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be es 1 and 2 should b of Health and Menta item 27 is marked Roger Meeks ပ Martha Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine J. Washington/ Companion 2412 Porter Ave. Suitland, MD 20746 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park Oct. 29, 2007 Landover, MD 21. Signature of Puneral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1☐ Yes 1 ☐ Yes 2 or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) **2**√ No Hospital: 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of eath Date of Injury (Month, Day Year) 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 2 Accident 5 Pending investigation Injury ours after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

or Vital Records, P.O. Box 68760

within 24 hours a

To the Funeral I

completely filled i To the Hospital

State

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) RAHIMIAN MD

32. Registrar's Signature

MD

and manner stated

Шинац

Registrar DHMH 17 Rev 1/2001

Medical

29a. Certifier

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0052999

7501 SURRATTS ROAD CLINTON

29d. Date signed (Month, Day, Year)

			For State	State of	Marylan		artment of F		and Me			arts were	
			Registrar  1. Decedent's Name (First, Middle,	Last)			lineale of	Dealli	2	Rote of Deat	eg. No. 2	107	36492
	Physic		Joseph Jeffers	· ·	7					Month Oct 2	Day 2007	Year	6:15 a.m.
	/Medi Examir		4a. Facility Name (If not institution,				4b. City, Town, o	r Location o		000. 2	4c. County		0:13 a.m.
		à.	Larkin Chase Nu	rsing Hon	ne		Bowie	j			Pri	nce	George's
	Funeral			6. Sex 1	7. Age (In yrs.		If Under 1 Year Months Days	If Under	24 Hrs. 8 Min.	Date of Birth			place (State or Foreign
1524	Director		578-44-1732	TAM ZOF	74	Yrs.			-	eb. 26,	1933	Wash	ington, DC
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary f sho	호	Maryland Princ	e George'	e Ro	owie							1X Yes 2 □ No
	r 28a	Director	10e. Street and Number	c dedige	5   100	JWIE_	10f. Zip Code			1	0g. Citizen of \	What Cour	ntry?
	h with		15005 Health C	enter Dri	ve		207	16			US.	Δ	
	deat deat	Funeral	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13. \	Was Decedent of H		gin? (Speci	fy Yes or No-	14. Rac	e - Americ	can Indian,
9	after or its	E.	1 X Never Married 2 ☐ Marrie		2 🔼 No		1 ☐ Yes 2 🏻 No	Specify:	i, Fuelto Ali	can, etc.)		k, White, גוו	etc. nite
9	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ites:						Specify	/: ***	1100
5	n 72 ł "nat edica	Completed	15. Decedent (Specify only highes	s Education grade completed)		16a. Deced	lent's Usual Occup kind of work done o DO NOT use retired	ation during most	t of working		16b. Kind of Bu	usiness/In	dustry
12	within ene. than he M	토	Elementary/Secondary (0-12)	College (1-	4or 5+)		.1 Hop	1)			н	ote1	
<b>d</b> 2	filed Hygi other ent, ti		17. Father's Name (First, Middle, L	ast)		301	100	18. Mothe	er's Name (F	First, Middle, N	Maiden Surnan		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	To Be	James Marley						Hatt	ie Mund	lev	,	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	g Address (Street	and Numbe				State, Zip	Code)
Z	and 2		Raymond Mundy -	Cousin		6007	Longfel:	low St	t., R	iverda1	e, MD	2073	37
Ore	of He fiter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	2 Dame - I fee - C		Place of Dispo	sition (Name of natory or other place	ce)	Dat	e :	20c. Location -	City or To	own, State
<u>Ē</u>	Pag ment ant: I		4 □ Donation 5 □ Other (Sp		Metr	opolitar	n Crematory	1	0/27/	07	Alexan	dria	, VA
Baltimore,	permit. Pages ' Department of H Important: If ite any Injury or ot		21. Sign ture of Funeral Service L	iomsey			. Name and Addres		•				nore Ave.
-	20 E # 9	\	1 Mobile (	1 Nonfe	HOING							ville	e, MD 20781
			23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications that ca niy one cause on ea	used the deatl ich line.	h. Do not ente	er the mode of dyin	ng, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Res	pirator	y Fail	ure					1	Onset and Death
	/Medical Examiner		resulting in death)		or as a conseq								
		-	Sequentially list conditions,	D	onary E		isease						
	nsit	Examiner	Sequentially list conditions, lia by leading to himsulate cause. Enter Underlying Cause (Disease or injury	333,040									
,	execu n and al-tra	xal	that initiated events resulting in death) Last	c Due to (d	or as a conseq	uence of):					<u>.</u>	_	
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical		ď									
9	tificat ig phy as th	ledi											
Вох	leath certific attending p	J/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome pf pregna rth 2□Feta		Ectopic pregnancy	,			23d. Dat	e of delive	ery
_	ed for	sicis	in the past 12 month <i>s</i> ? 1 ☐ Yes 2 ☐ No		int at time of d		Other (specify)				Mo	nth	Day Year
P.0	at the I by the stach	Physician/Me	9 ☐ Unknown										
Ś	requires that the de een signed by the a nould be detached f		Part II. Other significant condition General Del		ath but not resi	ulting in the ur	iderlying cause give	en in Part I.					ne cause of death?
oro	requi	ted	General Del	JIIILY					_	1 □ Ye	s 2 □ No	3 ☐ Prob	oably 4XIUnknown
Records,	2 38	Completed by								24a. Was ar autops	у ј	orior to co	psy findings available mpletion of cause of
	10 5	Cor								perform 1 Yes 2	ned? No	death? I □ Yes	2□No
Zi.	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Loth			Check only one	/		
Division or Vital	Phys r this ral dii	: To	1 Yes 2 No 27. Manner of Death	1 ☐ In		ER/Outpatient 28b. Time of		4 🖽 NU!			nce 6 Oth		y)
on	ding h. After fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	, Day Year)	Injury	Worl	yat (? Yes 2∐N	1	z. Describe no	w injury occurr	ea	
/ISI	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could no	at ho	of injury - At ho	me, farm, stre	eet, factory, office			. Location (Str	eet and Numb	er or Rura	il Route Number,
á	al or saffer	Certification:	4 ☐ Homicide determin	building	g, etc. (Specify	<i>(</i> )				City or Town			,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physician: To the b	pest of my kno	wledge, death	occurred at the tin	ne, date an	d place, and	d due to the ca	ause(s) and ma	ınner as s	tated.
	the H in 24 the Fi	Medical	one)	xaminer: On the bas and manne	er stated.	tion and/or inv	restigation, in my o	pinion, deal	th occurred	at the time, da	ate and place,	and due to	the cause(s)
	North With	Σ	29b. Signature and title of certifier				29c. License		7	29	d. Date signed		Day, Year)
)			· W	y,			טטע	)45217			10/2	26/07	
			30. Name and address of person w		,	, , , , ,	,						
			Adebowale Ajayi 31. Date filed (Month, Day, Year)	6201 0	reenbe	1t Rd,	#U15, Gr	eenbe	1t, M	D 207	40		
	Sta Registr	_	OCT 2 9 2007	Service X	1. Op	who							

DHMH 17 Rev 1/2001

*	Physic	
-	Exami	ner
	uneral irector	
Maryland	a-f show ified at	ctor

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a any Injury or other traumatic event, the Medical Examiner must be not

Baltimore, Maryland 21215-0036

Physician /Medical Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

	-	State Registrar Certificate of Death Reg. No. 2007 20103											
E		1. Decedent's Name (First, Middle, Last)  2. Date of Death											
ian		Marta Silvia Marks	200 7 Year	12:10P M									
ical ner		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location	of Death		4c.	County of Deat	h			
1101	d	Casey House		Rockvill	e			Mo	ntgomer	У			
			s. last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs.	8. Date of Bir	th Vear)	9. Birt	hplace (State or Foreign			
		214-45-9683 1□M 2XF	48 Yrs.	Months Days	Hours	IVIIII.	July 2	4, 1	959 Arg	gentina			
	Ì	Usual Residence of Decedent											
١.		10a. State 10b. County 10c. 0	City, Town or Lo	cation						10d. Inside City Limits			
Fineral Director		MD Montgomery Mor	tgomery	Village						1 □ Yes 2 No			
liro l		10e. Street and Number		10f. Zip Code				3	zen of What Co	ountry?			
-	3	18921 N. Meadow Fence Road		20886 USA									
2		11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of f Yes, specity Cut	<ol> <li>Race - Ame Black, Whit</li> </ol>								
									Specify: Whi	+0			
2		3 ☐ Widowed 4 ☐ Divorced Year or Dates:											
Completed	3	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	pation during mos	st of worki	ing	16b. Ki	nd of Business	f Business/Industry			
2		Elementary/Secondary (0-12) College (1-4or 5+) 5+		Therapis				M115	ic Ther	anv			
8	3	17. Father's Name (First, Middle, Last)	riusic	THETAPIA		or's Name	e (First, Middle			up)			
å	3	Jankil Grosmark			Celia			, maideir	alderi Gurriame)				
F	2		460 14 25	4.11				0.4	T- 00-1-	7.0.4100006			
		19a. Informant's Name/Relationship (Type. Print)								Zip Code) 20886			
	-	David F. Marks/husband  20a. Method of Disposition 20b	. Place of Dispo		ow re		Rd • MOT		cation - City or	lage, MD			
		1 ☐ Bunal 2 【Cremation 3 ☐ Removal from State	cemetery, cren	natory or other pla	ice)		Julo	200. LC	cation - only or	TOWN, State			
			esapeak	e Cremat	ory	10/			sville,				
8		21. Signature of Funeral Service Dicensete							e P.O. Box 784				
	4	Carey F Helall	101251Be	verly L.	Heck	rott	e, P.A.	Cla	rksvill				
		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode of dy	ing, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death			
		Immediate Cause (Final disease or condition Metastatic Ovarian Cancer											
	resulting in death)  Due to (or as a consequence of):												
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):												
Madical Evaminar													
80	3	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
ú	ì	Due to (or as a cons	equence on.										
15	5	d.											
Mo		IF FEMALE: 23c. If yes, outcome pf pres	102001										
0	3	250. Was decedent pregnant 1 Live birth 2 F	etal death 3 ☐	Ectopic pregnan	у				23d. Date of de Month				
ioi	2	1 □ Yes 2 ☒ No 9 □ Unknown 4 □ Pregnant at time of 9 □ Unknown	rdeath 5∟	Other (specify)									
Completed by Dhysician		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute											
ءَ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the underlying cause given in Part I.												
To to		24a. Was an 24b. Wer											
9	É		prior to	utopsy findings available completion of cause of									
ځ	3		1 7						performed? death? Yes 2.20 No 1 ☐ Yes 2 ☐ N				
a	3	25. Was case referred to medical examiner?  Hospital: Hospital:		0			h (Check only						
F		T Tes ZX No	ER/Outpatien	t 3□ DOA	4 🗆 N	ursing Ho	me 5 Res	idence	6 NOther (Spe	cify) hospice			
2	5	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year,	28b. Time of Injury	We			28d. Describe	now injui	ry occurred				
100	Tagnetatat S   Folkality   S   S   S   S   S   S   S   S   S												
1		3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At building, etc. (Spe	cify)	eet, lactory, office			City or To	wn, State	e)	ural Route Number,			
2	3	29a. Certifier 1X Certifying Physician: To the best of my	nowlodge death	h occurred at the	ima data -	nd place	and due to the	001100/-	\ and masses	o atatad			
Madical	2	29a. Certifier (Check only one) / 1 Medical Examiner: On the bast of my k    Medical Examiner: On the bast of my k   and manner stated.											
Mon		29b. Signature and title of certifier		29c. Licer	se number			29d. Da	te signed (Mon	th, Day, Year)			
		Herenene Waston -							ber 30				
1000										,			
		30. Name and address of person who completed cause of death (i Genevieve Wroblewski, M.D. 600	) l Munca	aster Mil	1 Rd.	Roc	kville	MD	20855				
ate		31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature					_					
trai	-		B. A.	berte									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Thomas Aquinas Meighan October 25, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 15€ M 2 ☐ F Director 728-05-0209 75 3, 1932 Washington, DC Sept. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Inst: If Item 27 is marked other than "natural", or Items 23a or 28a-f show mit: If Item 27 is marked other than "natural", or Items 2 and or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐Yes 2 No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10103 Georgia Avenue 20902 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 15 Yes 2 No If Yes, Give Year or Dates 1954-56 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Priest Religious 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John M. Meighan Idell Kirby P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Ranieri/Religious Supervisor 200. Place of Disposition (Name of cemetery, crematory or other place)

A 200 Harewood Road, NE Washington, DC 20017

Date Oct. 31, 20a. Method of Disposition Important: If it any injury or o 1 Buria! 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 ren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Urinary Tract Infection /Medical Due to (or as a consequence of): Examiner Clostridium Difficile Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the ca Due to (or as a nonsequence of): Examine ig physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 by Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Idiopathic Thrombocytic Purpura 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s autopu performed : 2 2 No or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D63195 October 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven D. Wilks, MD 9901 Medical Center Drive, Rockville, MD 20850 Steven D. Wilks, MD

State

Registrar

31. Date filed (Month, Day, Year)

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30

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32 Registrar's Signature

			1 - State Registrar	State of Maryland	•	rtment of H			iene	07	36495		
ĺ	Physici	an .	Decedent's Name (First, Middle, Last)     Shirley Ella	Mae Miller				2. Date of Dear Month	Day	Year	3. Time of Death		
-	/Medic		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death	OCT	31 4c. Coun	ty of Death	Cledy		
	LXGIIIII	٠.	11105 Shadybrook C	ourt		Hager				Washi	ngton		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan 1,	Year)	9. Birth	place (State or Foreign intry) Virginia		
H.	Director		232-02-1092 Usual Residence of Decedent					Jan. 1,	1900	Wesi	virginia		
	iryland show	_	10a. State 10b. County	10c. City, 7	Town or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2 No		
	he Ma	Directo	Maryland Washing	ton		Hagersto	wn		0g. Citizen o	f What Cou			
	3e or		11105 Shadybrook	Court			740		og. Oilizeir o	US			
	atter death with the Marylan or items 23e or 28e-f show	Funerai		2. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of Hi Yes, specify Cuba		pecify Yes or No-		ace - Ameri lack, White	can Indian,		
9	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23e or 28e-f show int, tra Medical Eval. It act must be mullifued.	by Fu	1 Never Married Married 3 Widowed 4 Divorced	1 ☐ Yes 2/1 No If Yes, Give		☐ Yes 2☐ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Spec	cify:			
Ş	should be filed within 72 hours afte nd Mental Hygiene. marked other than "natural", or ft imatic event, tra Munical Erar, in	ed p	15. Decedent's Educa			ent's Usual Occupa			16b. Kind of		hite ndustry		
<u>ლ</u>	thin 72 9.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed)  College (1-4or 5+)	(Give I life. D	aind of work done of ONOT use retired	during most of won )	king					
Maryland 21215-003	ygien ygien her th	Con	12			Housewif		ne (First, Middle,	Maridan Com	Home	<del></del> · · · · · · · · · ·		
and		Be c	17. Father's Name (First, Middle, Last)  Donald Lee Tayl	or				Ann H					
ary		10	19a. Informant's Name/Relationship (Type		19b. Mailin	Address (Street a					p Code)		
Ž	and 2 : salth ar n 27 is er trau		Betty Kimble - Sis				alley Dr				yland 21740		
ore ore	Pages 1 and nent of Healt int: if item 2: iry or other i		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State cem	netery, crem	ition (Name of atory or other plac		100	20c. Location	1			
Baltimore,	permit. Pag Department Important: i any Injury o once.		' 4 □ Donation 5 □ Other (Specify)  21. P nature of Funeral Service Licenses			Mem. Par			illiam	sport	, Maryland		
g	Depa Impo any i		1 Dilly M						lliams	port.	MD 21795		
H			23a. Part . Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.							Approximate Interval Between		
1	Physician	1	Immediate Cause (Final disease or condition	ENDOMETRI	AL	CARCIN	oma u	117# ME	TAST	4515	Onset and Death  UNKNELLA		
	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):								
		Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or se a consequa-	nea of):								
	cuted nd ransit	Examiner	that initiated events C.										
60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):								
28760	ate hy:	edicai	d.						12.				
ROX	eath certifica attending pl	Physician/Me	23b. Was decedent pregnant	c. If yes, outcome of pregnanc		Ectopic pregnancy					*		
	0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deal		Other (specify)				Month	Day Year		
P.0	The law requires that the tee has been signed by thoage 2 should be detached.									23d. Date of delivery  Month Day Year  co use contribute to the cause of death?  2 \[ \text{No} 3 \] \text{Probably} 4 \( \frac{1}{2} \) \( \text{Unknown} \)  24b. Were autopsy findings available			
ds,	puires that n signed b	d by						1 □ Y	es 2□No	3 ☐ Pro	bably 4XiUnknown		
Record	aw requisible bear	Completed						24a. Was a		o. Were aut	opsy findings available ompletion of cause of		
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Vital	Attending Physician: Thir death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	spital:		Oth		th (Check only or					
	Physi r this c ral dir	2	1 ☐ Yes 2 No 27, Manner of Death	1   Inpatient 2   EF	Outpatient  8b. Time of	3 □ DOA 28c. Injun	^{er:} 4 ☐ Nursing H	ome 5 x Resid 28d. Describe h			ify)		
0	nding P tth. :: After e funera	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No						
Division of	or Attenoration after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	VI 5	28f. Location (S City or Tow		nber or Rui	ral Route Number,		
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by			To the best of an in-									
	a Hosg 24 ho Fune etely f	edicai	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my knowless: On the basis of examinatio and manner stated.									
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			30. Name and address of person who con	4 4	23a) (Type, I	Print)	07 47	1 1131		Denie !	21740		
20	Sta	to.	KODUAH PEPRAI  31. Date filed (Month, Day, Year)	7 32+ C	re /	EIMM :	1111111	e Anc	ICKS 16	, 200	ar / TU		
	Regist		31. Date filed (Month, Day, Year)	Aller A.	Spork								

			For State	State	of Marylan	-	rtment of H		lental Hyç	giene	107	36496
В.			Registrar  1. Decedent's Name (First, Midd	Journ	Date of Death     3. Time of Death							
Ш	Physici /Medic		LULU CROCKET			Month 10/27/	Reg. No 2 0 0 7 36 4 9  the of Death Day Year / 27/2007 12:55 p  4c. County of Death Worcester  the of Birth Onth, Day, Year)  10d. Inside City Limit 1 12 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	Examir		4a. Facility Name (If not institution	4b. City, Town, or	Location of Death	,,		nty of Death	. 2003 p			
	Hartley Hall Nursing Home						Pocomok				Worcester	
и	Funeral	0.0010	5. Social Security Number	6. Sex 1 ☐ M 2 ★ F	7. Age (In yrs. I	Ven	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day	v, Year)	Coun	try)
	Director		213-22-7478 Usual Residence of Decedent		5	92 115.			9/2/191	5	Mary.	Land
	yland yland at		10a. State 10b. County	/	10c. City	, Town or Lo	cation				1	Od. Inside City Limits
	e Mar ta-fsl	ctor	MD Word	ester	Po	ocomoke	e City					1 XYes 2 No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
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	ter de item	Funeral	<ol> <li>Marital Status</li> <li>Married 2 Married</li> </ol>	Armed F			Vas Decedent of Hi f Yes, specify Cuba	ispanic Ongin? (Sp in, Mexican, Puerto	ecity Yes of No- Rican, etc.)			
036	urs af al', or xam	by	3 XWidowed 4 ☐ Divorce	If Yes. G	iive	1	☐ Yes 2☐No	Specify:		Spe	cify: whi	te
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2	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ខ	12 17. Father's Name ( <i>First, Middle</i>	/ act)		Homen	naker	19 Mathar's Name	2 /First Middle			2
and	be d c	Be C		,					Richards		iame)	
Maryland 2121	s 1 and 2 should be of Health and Menta item 27 is marked other traumatic ev	ို	Jesse Crockett  19a. Informant's Name/Relation			19b. Mailin	g Address (Street a				vn, State, Zip	Code)
	Health ar Health ar tem 27 is		Margie Aydelot	te (Admir	istrato	1						
re,			20a. Method of Disposition	·	20b. P	lace of Dispos	sition (Name of natory or other place	i	Date			
Ē	Pages nent of ant: If it any or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		n State		st Cemetery	1	/2007	Pocomo	ke Cit	y, MD
Baltimore,	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service	Licensee		22 HC	Name and Addres	s of Facility uneral Ho	ome, Pro	fession	al Assoc	iation
		7 0	23a. Part1. Enter the disease, of	r complications that	caused the death	110	)3 Linden	Ave., Po	ocomoke	City,	MD 218	351
	2huninian	2 (	shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.							Interval Between Onset and Death
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8/60,	icate be executed physician and s the burial-transit			Due to	(or as a consequ	rence or):						
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ň	death e atte d for	icia	in the past 12 months?	4□Preg	birth 2□Fetal nant at time of de		Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year
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Ś	es tha	by F	Part II. Other significant condit	ions contributing to	death but not resu	alting in the un	derlying cause give	en in Part I.		. /	,	e cause of death?
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		S								rmed? 2 Aro	death? 1 ☐ Yes	2 <del>210</del> 0
Vital		Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Deat				
ō	Physer this eral di	5	27. Manner of Death	28a. Date	e of Injury	ER/Outpatient 28b. Time of	28c. Injury	/ at	me 5 ∐ Resid 28d. Describe h			"
0	nding Ph th. r: After thi e funeral	tior	1 Natural 5 Pendi 2 Accident invest	ng ( <i>Mo.</i> igation	nth, Day Year)	Injury	Work	(? Yes 2 ☐ No		, ,		
DIVISION	il or Attend after death Director:	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be nined 28e. Plac	e of injury - At ho ding, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tow		mber or Rura	I Route Number,
5	spital or At burs after d leral Direc filled in by	Certification:		J	ang, etc. (opcony				Oity or You	n, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	ledical	29a. Certifier 1 ☐ Certifyl (Check only one) 2 ☐ Medica	ng Physician: To the Examiner: On the	e best of my know basis of examinat nner stated.	wledge, death tion and/or inv	occurred at the time tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the tight occurred at the t	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as st ce, and due to	ated. the cause(s)
	To the Hos within 24 hα To the Fun completely	Mec	29b. Signature and title of certific				29c. License	number			ned (Month,	
)	7.5		> Yaly	m.	0		000	62172		10/3	29/20	07
B	A5		30. Name and address of person SHARAU R	SATYAL,	ise of death (Item	23a) (Type, F	Print) 1 ARKET S	ST POUR	MOKE (	GTY DA	1) 218	51.
ĺ	Sta		31. Date filed (Month, Day, Year,	1 2007 32.	Registrar's Signat	ture A	books	. 000	. 10110	· · · · · · · · · · · · · · · · · · ·	<u>v = 10</u>	9:
	Registr	aı	001 9	- 2001		~ /						

DHMH 17 Rev 1/2001

		•	For State Registrar	State of	Marylan		artment of Hertificate of L		nd Me		giene Reg. No	2007	36497	
		Decedent's Name (First, Middle, Last)							2	2. Date of De	ath Da	ıv Yəar	3. Time of Death	
	Physici /Medic		MILDRED IRENE	DRED IRENE MOORE						Jovemb		2007	11:00 AM	
7	Examin		4a. Facility Name (If not institution, give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							County of Death			
			Harford Memorial									Harford		
	Funeral		5. Social Security Number 6. S	ex □M 2∏(F	7. Age (In yrs. 79	Yrs.	Months Days	Hours	Min.	B. Date of Bir (Month, Da L2/1/1	ay, Year,		place (State or Foreign intry) 'land	
	Director		212-26-3445 Usual Residence of Decedent		13					12/1/1	921_	Mary	Tand	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits	
	-i-	ctor	MD Harford		S	treet							1 ☐ Yes 2X No	
	or 28	Director	10e. Street and Number	- 1			10f. Zip Code				10g. Ci	itizen of What Cou	ntry?	
	eth w		3627 Conowingo	,			21154		-0./0	4. V-2. 22 No		USA 14. Race - Ameri	can Indian	
	item item	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Dece Armed For 1  Yes		.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origi n, Mexican,	Puerto Ri	ican, etc.)	)-	Black, White		
36	irs aft	by F	3 ∰ Widowed 4 □ Divorced	If Yes, Giv Year or Da	θ 11		1 ☐ Yes 2 ☐XNo	Specify:				Specify: Whi	te	
ŏ	be filed within 72 hours after deeth with the Maryland tal Hygiene. ad other then "naturel", or iteme 23e or 28e-f ehow event, the Mudical Enarther must be notified at	ted	15. Decedent's Ed			16a. Dece	dent's Usual Occupa	tion	of working	,	16b. h	Cind of Business/Ir	ndustry	
215	en "n	ple	(Specify only highest gra	College (1	-4or 5+)		kind of work done d DO NOT use retired)	uning most c	or working			0		
21	ed wi	Completed	7			Home	maker	10 11-11-1	la Nama /	First, Middle	Majda	Own Home		
ğ	be fill he off	Be	17. Father's Name (First, Middle, Last) Philip Tayson						tha V		, Maidei	n Sumame)		
ž	hould d Mer mark matic	ဥ	19a. Informant's Name/Relationship (	Tyne Print)		19b Mailir	ng Address (Street a				er. City	or Town, State, Zi	p Code)	
Σ	d 2 s th en t7 is		Shirley Van Hart		er		vergreen				_	21014	,	
ē	Heeli Heeli tem 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other place	1	Da	te	20c. L	ocation - City or T	own, State	
ě	Page ent of nt: #		ty□ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		state		rs Cemete		1/9/2	2007	Jar	rettsvil	le, MD	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene important: If item 27 is marked other then "naturel", or iteme 23a or 28e-f ehow way injury or other traumatic event, the Medical Examinat must be nutitied at ance.		21. Signature of Funeral Service Licer	5°° . 0	0 %	22	2. Name and Addres	s of Facility						
<u> </u>	88 = 8		Helping 1	Leve	led		arkins Fu					Delta, PA		
П	Physician /Medical Examiner		Interval Betw									Approximate Interval Between Onset and Death		
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g.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	emon	N9									
	exection and and rial-tra	Еха	resulting in death) Last Due to (or as a consequence of):											
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	dical		d										
9	artifica ing ph e as t	Med	IF FEMALE:											
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	al death 3	Ectopic pregnancy					23d. Date of deline Month	<i>rer</i> y Day Y <i>e</i> ar	
P.0.	that the death certific ed by the attending p deteched for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno	ant at time of cown	ieath 5	Other (specify)							
	res that this igned by be detected	/ Ph	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying cause give	n in Part I.		23e. Did	tobacco	use contribute to	the cause of death?	
ds	ruires n sign	d by								10	Yes 2	2 No 3 □ Pro	bably 4 Unknown	
Ö	s been si	olete								24a. Was			opsy findings available	
æ	The law te has	<b>Ε</b>   _ μ								utopsy prior to completion of causer enformed? death? Is \$20 No 1 \( \text{Yes} 2 \( \text{No} \)				
ital	ian: rtifice ctor, p	Bec	25. Was case referred to medical examiner?					26. Place o	of Death (	Check only	one)			
Ž	Physician: r this certificant ral director, i	2	1 ☐ Yes 2 No		·	ER/Outpatier		4 Li Nurs				6 ☐Other (Spec	ify)	
D	ing P After t unera		27. Manner of Death 1 Natural 5 □ Pending		of Injury th, Day Year)	28b. Time o Injury	Work	at :? ∕es 2 ∐ N		d. Describe	ribe how injury occurred			
Si	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At h	ome farm st				3f. Location	(Street a	and Number or Ru	ral Route Number,	
Division of Vital Records,	after after Direct	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page						h occurred at the tim							
	the Ho in 24 the Fu pletel	edicai	one)		ner stated.	ation and/or in	vestigation, in my op			Jat the time				
	Withi To the	Σ	29b. Signature and title of certifier	,	116		29c. License	number 6	777		290. D	ate signed (Month	Day, Year)	
	_		, , ,		V V	= 22a) /T	17	DC C	) = (	7500	AV	7//		
	8		30. Name and address of person who	C +/F.S.A	PEAU	F (1)	2, B/-C	ATR	N	D 2	101	4		
	Sta	ite	31. Date filed (Month, Day, Year)	32 R	egistrar's Sign	ature	200	1 11		r				
	Regist		NOV 1 4 20	107	liter &	1. 190	Mil)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mowry Nov 4. 2007 2115 Patricia <u>Ann</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lee Master Lane Allegany Ellerslie If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) MD Min. Months Davs 1 □ M 2 □ F Hours Director Jan 30, 1948 219-54-1643 59 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Ellerslie Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with P.O. Box 94 21529 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ②
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important; if item 27 is marked other than "important; if item 27 is marked other than "any Injury or other traumatic event; the Med Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 12 Aide-Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Garlitz Margaret (Gordon) Garlitz Printy 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21555 24501 Gorman Road SE Oldtown Margaret Printy mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/8/2007 Restlawn Memorial Gardens MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Septice Lice ve 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Dank Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 cute 111 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Metastatic Obacian Sequentially list conditions if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sician and burial-transit certificate be executed Due to (or as a consequence of) attending physician the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1□ Yes 2 1 No 2FTNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence this 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 ⊡-Natural 5 ☐ Pending investigation Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0005940

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2

State Registrar 31. Date filed

SETON

DR. SUITE 203 CUMBERLAND, MD21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

902

32. Registrar's Signature

amend line 20b per place Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 10/26/07 divate of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 22 2007 **Physician** Lelia Norris 6:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Elder Care @ Spa Creek Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Davs 1 M 2 F Hours Min Director 212-58-8422 59 Maryland 1947 10 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Anne Arundel Director Annapolis 1 DNyes 2 DNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 169 O'Berry Ct. 21401 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any hijury or other traumatic event, the Medical Examiner must. once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker N/A 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Elijah Galloway Arlene Brown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lelia L. Norris(Daughter) 64-2 Julianna Circle E Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 10-29=07

Church U.M. Church 10-30-07 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State West River, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Warname Rockers of Secilifyons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 eese 1160 483 arry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 Do
9 Unknown Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐Pobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death | Director: / d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide n 24 hours the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hos within 24 ho To the Fun completely i (Check only and manner stated. 29b. Signature and title of certifier 29c. License number UMMe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State OCT 26 2007 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lillian R. Nicholoff October 24^y. 2007^{ar} 9:32 Α /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Prince George's Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth

(Month, Day, Year)

July 7, 1927 9. Birthplace (State or Foreign **Funeral** Months 204-18-0175 1 □ M 2 ☑ F Days Hours 80 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Maryland Prince George's Brandvwine Director 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10505 Cedarville Rd., Lot 7-2 20613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No <u>a</u> Specify: 3 Nidowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th. any injury or other traumatic event. th the School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Treitz Mildred Wolfe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Nicholoff Jr. / Son 1594 Ensenada Dr., Orlando, Florida 32825 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 10/28/2007 Edgewater, Maryland 4 Donation 21. Signature of Funda Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MeTESTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 61 75 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy pérformed? 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 4 No 1 [4 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death

Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of eertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern Ave. Si BoTello 132 ime wo D 31. Date filed (Month, Day, 32. Registrar's Signatu State OCT 2 9 2007

DHMH 17 Rev 1/2001

Registrar